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ROUTINE TESTING FOR THE RH FACTOR IN A MIDWIFERY HOSPITAL.

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DURING the few years that have elapsed since the discovery of the Rh factor in human blood, numerous studies on clinical, technical, genetic and anthropological aspects of its importance have resulted in the building up of an immense literature. Levine's⁽¹⁾ correlation of the Rh factor with those conditions collectively termed erythroblastosis or in later terminology hæmolytic diseases of the newborn, has gradually led to the conclusion that the Rh type of all pregnant women should be determined early in pregnancy.

The lack of sufficient quantities of suitable anti-Rh serum and the cumbersome methods used for detecting the Rh agglutinin have been limiting factors in the routine testing of all patients at ante-natal clinics. Gradually simplifications in technique have been devised, and now the only limiting factor is the stock of anti-Rh serum which is available. In our experience anti-Rh serum of high titre is rare, but that of a usable titre is obtainable from time to time. Sometimes this serum retains its potency for many months, but there is no means of assessing its keeping properties. In spite of these difficulties sufficient serum has been secured during the past two years for the routine examination of the Rh factor in the blood taken from all patients attending the ante-natal clinic of this hospital. During the past twelve months many requests for Rh tests on patients in the gynaecological section of the hospital and on private patients from various outside clinicians have been received, and during 1946 at least 1,000 samples of blood have been tested every month.

The conglutination test of Wiener⁽²⁾ and Diamond's⁽³⁾ test, with red blood cells suspended in 30% albumin solu-

tion make possible the use of serum containing blocking antibodies as well as serum containing the ordinary agglutinating antibodies. When supplies of this 30% human albumin solution become more generally available, the amount of Rh typing serum should be adequate to meet all demands.

Studies on the Rh factor in pregnancy have been carried out under a grant from the National Health and Medical Research Council. Although no new facts have been revealed as the result of this work, critical examination of various techniques has resulted in the selection of simple and reliable methods for testing large numbers of specimens of blood in the shortest possible time. In the present paper we propose to discuss routine testing for the Rh factor in a midwifery hospital, whilst the clinical results will form the substance of a later paper.

Original Routine for the Detection of the Rh Factor.

While typing sera for the A and B factor are readily available, anti-Rh serum is obtainable from the following three sources only: (i) hetero-immune serum from guinea-pigs which have been injected with suspensions of red blood cells from the rhesus monkey; (ii) iso-immune serum from Rh-negative patients who have suffered transfusion reactions as the result of being transfused with Rh-positive blood; (iii) iso-immune serum from mothers who have recently been delivered of babies suffering from erythroblastosis.

The only reliable source is the last named, since it is difficult to obtain reasonable amounts of blood from the few patients who develop a high titre of antibodies as the result of transfusion reactions due to Rh incompatibility. Further, animal sources have proved to be disappointing, since it is difficult to obtain a sufficiently high titre of antibodies, and this titre is decreased by dilution during the removal of other antibodies which react with all blood groups. Even after purification animal serum cannot be used to test the blood from newborn infants.⁽⁴⁾

Technique.

In the earlier methods of testing for the Rh factor, one drop of anti-Rh serum of compatible blood group, one drop of 2% suspension of the patient's red blood cells in

¹ Work done with the aid of a grant from the National Health and Medical Research Council.

Rous Turner mixture (glucose-citrate solution) and one drop of normal saline solution were placed in a small, round-bottomed agglutination tube. After thorough mixing the tubes were incubated at 37° C. and the results were read at half an hour, one hour and two hours. The two methods for determining the result were (i) inspection of the cell pattern through the bottom of the tube with the aid of a hand lens⁽³⁾ and (ii) microscopic examination of a streak of the sediment on a glass slide. In the latter method great care had to be taken to avoid breaking up the clumps. Some workers advised centrifuging before microscopic examination of the deposit.⁽⁴⁾ Simmons and co-workers⁽⁵⁾ used one drop of a suitable anti-Rh serum mixed with one drop of a 5% suspension of the patient's serum on a glass slide. The whole was then incubated in a moisture chamber at 37° C. In most instances excellent agglutination was detectable by the naked eye after incubation for fifteen to thirty minutes. Although slightly less sensitive than the tube test, this method has proved invaluable in routine testing, since the result is easy to read, and is less trying to the eyes. A further advantage is the shortening of the time necessary before the result can be read. In early reports certain workers thought that reactions took place more readily at lower temperatures than at 37° C. It was therefore necessary to test each sample both at room temperature and at 37° C.

In our earlier investigations the routine adopted was as follows. Cell suspensions from each patient were incubated with anti-Rh serum and saline solution in tubes at 37° C., and also two slide tests were set up, one being incubated in a moisture chamber at 37° C. and the second allowed to stand in a moisture chamber at room temperature. In the tube tests, inspection of the sediment pattern was used to decide whether the result was positive or negative. The microscopic method was found to be too tedious and time-consuming for routine work. It was, however, very helpful in picking out weak reactions missed by the slide technique and by the reading of the sediment pattern in tubes. The microscopic method was therefore employed to confirm the result in doubtful and apparently negative findings.

Original Methods for the Detection of Rh Antibodies.

One drop of the suspected serum and one drop of normal saline solution were placed in each of twelve agglutination tubes. A drop of one of the 2% red blood cell suspensions prepared from the blood clot of ten different group O Rh-positive persons and two group O Rh-negative persons was added to each tube and the components were thoroughly mixed. After incubation for half an hour, one hour and two hours respectively the cell pattern of each tube was inspected. The presence of Rh antibodies was indicated by agglutination of any of the group O Rh-positive cells, the Rh-negative cells being included merely as controls. Many specimens of serum will cause clumping of all the selected Rh-positive cells, but two factors may result in the agglutination of only some of them. These factors are either the presence of a low titre of antibody or the presence of antibodies of one of the Rh subtypes. While the usual standard anti-Rh₀ serum agglutinates 85% of the red cells of white persons, anti-Rh' serum will agglutinate only 70% of them and anti-Rh'' will react with only 30% of such cells.

When antibodies were detected by the tube method the serum was tested against the same set of group O Rh-positive and Rh-negative cells on slides. If definite agglutination could be detected without the aid of a hand lens, the titre of antibodies was considered sufficiently high for the serum to be used for Rh typing. The actual titre of the antibodies can be determined by testing serial dilutions of the serum against group O Rh-positive cells, including those giving very strong and very weak reactions against other specimens of anti-Rh serum. Among 25 patients whose serum showed considerable agglutination with the slide technique, the highest titre in tubes was 1:32. Three specimens gave excellent results when diluted 1:8, ten specimens when diluted 1:4, and four specimens when diluted 1:2. The remaining seven specimens caused agglutination when used in the concentrated form. Usually

a serum will give greater agglutination in the tube than on the slide, although occasionally a more satisfactory result is obtained on slides.

The frequent absence, or presence of only a low titre, of Rh antibodies in the serum of mothers whose children were severely affected by erythroblastosis, was a puzzling feature until Wiener⁽⁶⁾ described the "blocking" antibody. This antibody was reported independently by Race and co-workers,⁽⁷⁾ who termed it the "partial" or "incomplete" antibody. Wiener demonstrated its presence in the following way. If a tube test failed to show the presence of Rh-agglutinating antibodies in suspected serum, he added a drop of potent anti-Rh serum to the mixture in each tube. After thorough mixing and incubation at 37° C. for one hour the cell pattern was again inspected. Normally this potent anti-Rh serum will cause clumping of the group O Rh-positive test cells. Its failure to cause this effect indicates the presence of the "blocking" antibody. It is thought that the blocking antibody has the power to "sensitize" the cells, but is not able to cause their agglutination. Cells so sensitized cannot be clumped by the agglutinating Rh antibody present in other serum. A control row of tubes containing group O Rh-positive and Rh-negative test cells, saline solution and potent anti-Rh serum is incubated under the same conditions as the row containing the comparable test cells, the suspected serum and the same potent anti-Rh serum. By contrasting the agglutination in the two sets of tubes, complete or partial blocking can be detected. However, this test is not completely satisfactory. It is easy to detect complete blocking or the presence of a large amount of blocking antibody associated with only a small proportion of agglutinating antibody. If, however, equivalent amounts of each type of antibody are present in a particular specimen of serum, the presence of the blocking antibody only will be detected, since there seems to be a preferential attraction between the Rh agglutinin and this type of antibody. Thus the agglutinating antibodies will be missed even if they are present in fairly high titre. The presence of small amounts of blocking antibody is likely to be completely overlooked when they occur in conjunction with a high titre of agglutinating antibody.

The publication of still another test by Wiener⁽⁸⁾ has made the detection of blocking antibody and its differentiation from the Rh-agglutinating antibodies much more satisfactory. Wiener has shown that group O Rh-positive cells suspended in homologous serum instead of in the Rous-Turner mixture are agglutinated not only by the Rh-agglutinating antibody, but also by the blocking antibody. The reaction with the blocking serum is said to be due to the presence of conglutinin in the serum, and hence the test is termed the conglutination test. Coombes, Mourant and Race⁽⁹⁾ have recently queried the correctness of this interpretation and the suitability of the term "conglutination test"; but for the purposes of the present paper Wiener's nomenclature will be used. The extensive and persistent rouleaux formation which occurred in our first trials of this method gave the impression that the method was unlikely to be satisfactory. However, the specimens of group AB serum used as suspension and dilution fluids in these tests were obtained from pregnant women or from patients with bacterial infections. Serum from such sources is apt to cause rouleaux formation even in ordinary blood-typing tests. Since we have used serum from suitable normal healthy donors we have found the conglutination test to be satisfactory; slight rouleaux formation observed when fresh serum is used disappears after the serum has been stored for a few weeks.

Diamond's⁽¹⁰⁾ method, in which 30% human or bovine albumin solution instead of Rous-Turner solution, or serum, is used for suspension of the red blood cells, is a still later development. Considerable clumping occurs when cells suspended in this medium are mixed with serum containing Rh-agglutinating and blocking antibodies. At the present time these albumin solutions are not obtainable in Australia, but it is hoped that supplies will soon be available. The use of the albumin solution as the suspension medium, as well as producing more obvious clumping, avoids rouleaux formation.

It was thought that solutions of egg albumin might prove a satisfactory substitute for human or bovine albumin. We have tried two commercial preparations in addition to egg white itself, each being dissolved in water and normal saline solution. Even if the test cells simply suspended in each type of medium were incubated in a moisture chamber at 37° C., it was found that clumping occurred. This effect was enhanced when the cell suspensions in the various media were mixed with serum free from antibodies before incubation. However, although these solutions were useless for the detection of Rh antibodies, it is possible that purer preparations may prove more effective.

Until the middle of 1945 the routine already described was carried out on all specimens submitted for investigation. Those specimens which appeared to be Rh-negative were checked with several specimens of anti-Rh serum, including one capable of detecting the Rh' factor. Only recently has testing for the Rh' factor been possible. The serum from all Rh-negative blood samples was tested for Rh antibodies of the agglutinating type. Tests for blocking antibodies were commenced in the latter part of 1944. When Rh antibodies were detected in the serum of Rh-negative mothers some time before term, the titre of the antibodies was determined at intervals throughout the pregnancy.

When a patient was found to be Rh-negative the blood of the husband was requested for investigation, so that the likelihood of erythroblastosis could be excluded in those families in which both parents proved to be Rh-negative.

Routine Methods Now Used in Testing for Rh Factor.

The methods of testing previously described proved tedious for large-scale routine work. The microscopic technique for reading the results of the tube tests was early discarded except as a confirmatory test in doubtful cases. Tests by means of duplicate slides, one of which was incubated at 37° C. and the other at room temperature, proved of little value, since the results of the two methods were identical except for an occasional cold agglutination during winter months. The test at room temperature has therefore been discarded.

It was soon realized that slide tests could be used for eliminating from further investigation all specimens of serum except those giving weak positive and negative results. By the testing of each red blood cell suspension against two specimens of anti-Rh serum, false reactions due to contamination or other causes could be avoided. If all Rh-negative and doubtful reactions were then checked by the testing of these red blood cell suspensions against several specimens of anti-Rh serum in tubes, the correct Rh grouping of all blood specimens was assured.

Routine Methods Now in Use for Detecting Rh Antibodies.

A much simpler technique has been substituted for the tedious tube test for Rh agglutinins which had to be followed by the blocking test on all specimens of serum in which no agglutinins were detected. This method has proved an advantage, in that the time factor is greatly reduced and eye strain is almost eliminated. Perhaps its greatest value is in the conservation of the limited supplies of potent anti-Rh serum.

We have replaced the original procedure by conglutination tests on slides. Five per centum red cell suspensions prepared from the clot of five group O Rh-positive and one group O Rh-negative blood samples are mixed with the suspected serum in compartments on a large glass slide and the whole is incubated in a moisture chamber at 37° C. for thirty minutes. Such tests will detect both agglutinating and blocking antibodies. In the few instances in which antibodies are detected, the serum is retested by running a conglutination test on slides in parallel with one in which Rous-Turner solution is used as the suspension medium. Any clumping in the test with Rous-Turner cell suspensions indicates the presence of agglutinating antibodies, and increased clumping in the

conglutination test indicates the probability that blocking antibodies are also present. If agglutination of the Rh-positive cells occurs in the conglutination test only, then blocking antibodies alone or together with a low titre of agglutinating antibodies are present. The latter may be excluded by the application of a tube test, in which the serum is incubated with the test cells suspended in Rous-Turner mixture, and by proving the absence of any clumping even when the residue is examined microscopically. The suspensions of red cells in homologous serum are satisfactory for several days if kept in a refrigerator when not in use. By random selection of group O Rh-positive test cells, anti-Rh' and anti-Rh'' agglutinins may be occasionally missed. However, it is not always possible to have stocks of the various types of Rh cells available for large-scale routine work. If erythroblastosis is suspected and the routine testing has failed to reveal either agglutinating or blocking antibodies in the mother's serum, it should then be tested against Rh₁ (Rho'), Rh₂ (Rho'') and Rh-negative cells. Such a procedure will detect anti-Rh', anti-Rh'' or anti-Hr agglutinins.

Routine Methods Now in Use for Determining the Titre of Rh Agglutinating and Blocking Antibodies.

The titre of blocking antibodies is determined by the method of Diamond and Denton,¹⁰ in which the agglutinin titre is estimated by incubating serial dilutions of the serum in saline solution with group O Rh-positive red blood cells suspended in Rous-Turner mixture. The titre of the total antibodies present in the serum can be similarly determined by using homologous serum instead of saline solution or Rous-Turner mixture, for the suspension of the Rh-positive red blood cells and also for the dilution of the anti-Rh serum. The titre of the blocking antibodies is estimated by the difference in the titres obtained by the two methods. However, Boorman *et alii*¹¹ have shown that the clumping of red blood cells by serum containing weak agglutinating antibodies is enhanced by suspending them in serum. Wiener therefore contends that there must be a pronounced difference in the titre of total and agglutinating antibodies detected by the method described before blocking antibodies can be held to be present. Neither of these types of antibody has yet been isolated in a pure form, and it seems likely that nearly always both types of antibody coexist in all specimens of serum, but in varying proportions. The enhancing effect could therefore be due to relatively small amounts of blocking antibody, detected only when serum was used as the suspending and diluting medium.

Until recently the method of determining the titre of the antibodies seemed to be a reasonable matter; but in the light of the results of Boorman and others,¹¹ in which variable effects were observed with different diluting sera but with the same test cells, further investigation is necessary in order to evolve a method by which a standard titre for any serum can be obtained.

Discussion.

Since means for detecting blocking antibodies have been available, it has become possible to confirm the clinical suspicion that jaundice or stillbirth was due to erythroblastosis, in cases in which no agglutinating antibodies, or only traces of them, were detected in the mother's serum. Amongst the Rh-negative mothers who were tested before the introduction of the conglutination test, were 37 whose babies according to clinical findings suffered from erythroblastosis. Only 21 of these mothers had Rh-agglutinating antibodies in their serum. In 16 cases, therefore, the clinical diagnosis could not be confirmed by the laboratory findings.

Since the introduction of the conglutination test 28 similar cases have been observed. In only 10 of them were Rh-agglutinating antibodies found in the serum; but all the other 18 patients proved to have considerable amounts of blocking antibodies in their serum. Wiener was the first to suggest that the presence of the blocking antibodies in the blood of mothers of children suffering from erythroblastosis explains the puzzling lack of correlation between

the titre of Rh agglutinins in the maternal serum and the severity of the disease in the infant. He suggests that the blocking antibody may be of greater clinical significance in the causation of this condition than the Rh-agglutinating type of antibody.

Wiener⁽²⁾ even goes further and suggests that high concentrations of blocking and agglutinating antibodies have different effects. The blocking antibody seems to be the more detrimental to the fetus, and when it occurs in high concentrations stillbirths can be expected. Somewhat lower concentrations cause *icterus gravis* of a degree that requires blood transfusion. The agglutinating antibody seems to be on the whole less detrimental, but is responsible for the occurrence of kernicterus. This Wiener suggests is caused by clumping of red blood cells in the arterioles of the basal ganglia with subsequent anoxemia and damage to these structures. They are then stained by the circulating bilirubin, with the production of the typical effect observed at post-mortem examination. If the child survives until the jaundice has disappeared, the post-mortem investigation will reveal cerebral damage but no kernicterus.

Diamond and Abelson⁽³⁾ agree with Wiener that the presence of blocking antibody indicates that the patient has undergone a high degree of immunization and that the infants of women whose serum contains blocking antibodies are certain to meet disaster. Thus they contend that the repeated performance of quantitative estimations of blocking antibodies is of no clinical importance. Serial quantitative estimations of ordinary agglutinins are, however, of considerable value, since an increasing strength of this type of the Rh-antibodies only in the latter months of pregnancy indicates the growing danger to a fetus that has a fair chance of survival. A single test showing the presence of agglutinins does not lend itself so easily to clinical interpretation, since a low titre of agglutinating antibody may denote either early sensitization or profound late sensitization, depending on the presence of inhibitor substances or blocking antibodies.

Although these statements are probably true when blocking antibodies have arisen as a result of the present pregnancy, there is one important exception to these generalizations. In the case of a family in which the father is heterozygous for the Rh factor, antibodies of both types, formed as the result of a pregnancy in which the child was Rh-positive, may conceivably persist in the mother's serum and be present during a following pregnancy in which the child happens to be Rh-negative. Serial quantitative estimations may reveal stationary or decreasing amounts of both antibodies, indicating the possibility of a favourable outcome in such instances. A study of the past history of the patient will often show whether this interpretation of the present laboratory findings is possible.

Whilst a correlation between the laboratory and clinical findings in our series of more than 6,000 patients will be the subject of a subsequent paper, it may be mentioned now that in eleven cases the clinical evidence and the information obtained from the laboratory investigations seemed to be contradictory. In ten of these cases both the mother and baby were Rh-negative, and yet Rh antibodies were detected in the mother's serum. Six of the babies were normal, and since five of their mothers were *multi-paræ*, persistence of antibodies produced in a previous pregnancy could explain the contradictory findings in the present pregnancy. In the other four families the babies were jaundiced, two of them so severely that blood transfusions were necessary. Antibodies were found in the blood of all the mothers. Persistence of antibodies from a previous pregnancy, which was possible in the case of the two *multi-paræ*, could not account for the occurrence of jaundice in these Rh-negative babies. An explanation for these four cases and for the sixth in the previous group may perhaps be found in Rh subtype incompatibility; that is, the mother may be subtype-negative and the baby subtype-positive. The antibodies would then be due to this subtype incompatibility. Another explanation of these facts may be found in Wiener's suggestion that the baby's

cells may have become sensitized to blocking antibodies in its own serum, and therefore be incapable of agglutination by Rh-testing serum.

A word of caution may be added with regard to the possibility that false negative results may be obtained when cord blood is examined. It is a routine procedure in this hospital to examine both maternal blood taken on the day of delivery and cord blood in families in which the mother has been proved to be Rh-negative in antepartum tests. In several instances the cord blood appeared to be Rh-negative; but the baby developed severe jaundice. A second sample of blood was obtained, this time from the baby itself, and was found to be Rh-positive. We first thought that the cord blood might have become contaminated, but in some cases in which anti-Rh testing serum showed the presence of bacteria, false positive and not false negative results were obtained. Two factors may explain the different results obtained by testing the cord blood and that drawn directly from the baby. Firstly, the baby's blood was usually obtained twenty-four to forty-eight hours after the cord blood had been tested. During this period the child's cells may have combined with the available blocking antibody, an excess of cells (which probably included many newly formed cells) being left to react with the Rh-typing serum; thus the result made the baby Rh-positive. Secondly, the cord blood is obtained from the placental end after the cord has been tied and cut. It has thus been in contact with the maternal blood for a longer time than when the normal circulation is proceeding. This would allow the chance for absorption of a greater concentration of antibodies from the maternal blood. Sufficient blocking antibody would result in preventing agglutination of the cord red blood cells, and the blood would be said to be Rh-negative.

The eleventh family is worthy of mention, in that the red blood cells of both the mother and the baby were agglutinated by standard anti-Rh₀ serum. This type of serum reacts with Rh₀ (Rh') and Rh₁ (Rh'') cells, which are both fairly common among white races, as well as with the Rh₂ red cells, which are rare in such people. Agglutination of the red blood cells of both the mother and baby occurred when these were tested with anti-Rh' serum, which reacts with Rh₀ and Rh' cells. The appearance of jaundice in the baby led to further investigations. The maternal serum agglutinated only two of the ten specimens of group O Rh-positive test cells. Further, the baby's red blood cells were agglutinated by its mother's serum. No clumping of Rh-negative cells was observed, hence Hr incompatibility was eliminated; anti-A and anti-B reactions were also excluded. Incompatibility due to difference in rare Rh subtypes between the mother and child might possibly have explained the results obtained, but lack of suitable serum prevented the performance of such investigations. At the time of writing a similar case has been found. The baby and mother both had group O blood. The red blood cells of each were agglutinated by standard anti-Rh serum and by anti-Rh' serum. We are fortunate in having some anti-Rh'' serum, and tests against this serum showed that the mother was Rh''-negative, whilst the baby was Rh''-positive. The mother's serum was found to contain a high titre of Rh''-agglutinating antibodies.

Conclusion.

By the use of simplified methods embodying the most recent developments of the conglutination test and Diamond's albumin suspension method, the routine testing for the Rh factor of all patients in maternity hospitals has passed from the realm of desirable possibility to that of practical reality.

Summary.

1. Early methods for detecting the Rh factor and Rh antibodies are reviewed.

2. Wiener's blocking and conglutination tests and Diamond's albumin suspension method for testing for Rh antibodies are described.

3. Modifications of earlier techniques in the light of these tests provide simple and rapid methods for routine testing for the Rh factor and Rh antibodies.

4. Problems arising from investigations with the earlier methods are explained by these later additions to our knowledge.

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A FURTHER REPORT OF AN EPIDEMIC OF ACUTE POLYARTHRITIS.

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DURING the past few years attention has been drawn on several occasions to a condition characterized by painful, swollen joints, lymphadenitis and a transient exanthem. In 1934, Horan and Halliday described an epidemic of this disease and applied to it the term "acute polyarthritis". Two other reports have since then been published, one by Sibree and the other by Dowling. Like the first, these latter outbreaks occurred among troops stationed in areas to the north of Australia. Another reference to this condition is made by Nimmo, in a letter to *THE MEDICAL JOURNAL OF AUSTRALIA*, in which he draws attention to a paper published in this journal in 1928. The cases

described in this last-mentioned paper, although they presented a number of features in common with those described more recently, differed noticeably in the nature of the rash, in the severity of the systemic disturbance and also apparently in the fact that lymphadenitis was not observed in them. However, it is interesting to note that an epidemic having many features in common with those more recently described did occur some fifteen years before in the Riverina district of New South Wales.

These are apparently the only references to be found in the literature. Some fifteen months after the epidemic described by Horan and Halliday occurred, I was stationed at a Royal Australian Air Force unit in the same area, and had the opportunity to observe yet another outbreak of apparently the same condition. It is on these observations that the present report is based.

Since returning from the area, I have discussed the condition with Dr. J. H. Halliday and shown him such records as were kept. He agreed that the cases described here are similar to those observed by Dr. J. P. Horan and himself. Although the literature now contains the several references mentioned earlier, it is unlikely that the conditions obtaining during wartime, primarily the habitation of the northern areas of Australia by large numbers of men, will be reproduced at least for some time, and consequently it seems desirable to record observations made in these parts during the war years. For this reason, this paper based on 51 patients (of whom I was one) has been prepared.

Clinical Features.

There was an extremely wide variation in severity amongst these cases. Some patients presented the full syndrome of a rash, painful swollen joints and adenitis, while others complained of nothing more than a painful limitation of movement in several joints. Sixteen required treatment in hospital, and the remaining 35 were treated as out-patients, in some cases with a slight modification of their daily duties.

The initial complaint in almost every case was of pain in several joints. In a number of cases this came on suddenly with swelling of the affected joints; but more frequently the patients stated that they had noted some stiffness and dull aching in their joints for several days, and this had gradually increased in severity. Severe constitutional disturbance was not common. In all except three cases the entire course of the illness was free from malaise.

One man presented himself with the typical rash as the initial symptom. In the other cases in which the exanthem appeared, it was at a variable stage, usually from twenty-four to forty-eight hours after the pain had commenced. Mild pyrexia was usual in the more severe cases.

The course of the illness was mild. The pain, which was really the only troublesome feature, was in the more severe cases relieved by rest and much aggravated by movement. Normally after four or five days this pain had been replaced by stiffness in the joints with some tenderness on full movement. This persisted for some time; but it was found that those patients who carried out the instruction to commence exercises as soon as the acutely tender stage had passed, completely recovered a considerable time before the others.

Some tenderness and enlargement of the lymph glands, especially in the axillae and inguinal regions, were usual. Although the tenderness in these glands disappeared within the first week, the enlargement persisted, in one or two cases even long after all symptoms had cleared.

The duration of the illness ranged from a few days to several weeks. The average period of stay in hospital was 8-25 days. More than 90% of the men receiving treatment as out-patients had completely recovered by the seventh day. In a number of cases, however, residual stiffness persisted. This was not painful, and there was no tenderness to pressure. It was found that the stiffness was not pronounced after a period of inactivity, notably immediately after arising in the morning, and disappeared after the patients had been moving about for a time. In all except one case, this stiffness had cleared within four weeks.

In no case could signs be found of severe focal infection, respiratory tract disease or alimentary disorder. Also in no case was any sign of even temporary cardio-vascular disorder detected.

Joint Manifestations.

Joint manifestations were outstanding features of the illness. Pain in several joints was present in every case. In a few, the pain had been severe from the onset of the disease, but more commonly it had commenced as a dull ache and had gradually increased in intensity until the maximum was reached some twenty-four to forty-eight hours after the onset. In the early stages of the illness, the pain was aggravated by movement and greatly relieved by rest. The majority of patients found that while lying in bed they experienced little more than a dull ache. The duration of severe pain varied from two to five days, after which stiffness remained in the joints for a variable time. In the latter phase it was found that movement was beneficial, the stiffness rapidly disappearing after a short period of activity.

In almost every case tenderness to pressure was present over the affected joints, a point of maximum tenderness being usually situated somewhere over the joint capsule. In several cases the tendon insertions near the joints and the tendons themselves were tender.

In fifteen cases swelling of the joints was observed. In two of these this was due to a synovial effusion, while in the remaining thirteen it appeared to be due to a peri-articular reaction. Usually this joint enlargement was not present at the onset, but developed during the first twenty-four to forty-eight hours, and reached its maximum when the pain was most severe. This swelling of the joints affected was in most cases quick to subside, although the intracapsular type of swelling was much more persistent than the periarticular type.

Early in the course of the illness, several patients also complained of pain in the back, neck and limbs. This appeared to be myalgia and did not present the typical features of the joint pains. The large as well as the small joints of the limbs were affected, although it is doubtful whether any case of involvement of either the hip or the shoulder was encountered. Several patients complained of pain in these regions, but it was considered that this was almost certainly of muscular origin and did not result from any joint affection. The condition actually showed no predilection for any particular joints, although in these cases the probable order of affection was as follows: interphalangeal joints, knees, ankles and elbows. The intervertebral joints could not be considered to have been involved in any case, and there was no evidence of muscle wasting at any stage of the illness.

Since recovery, no residual deformity or limitation of movement has been encountered and there has been no recurrence of symptoms.

Fever.

Twelve patients, all suffering from the more severe form of the disease, were found to have a rise in temperature ranging from 99° to 105° F. The usual readings were from 99.6° to 100.6° F., and the temperature returned irregularly to normal in from four to six days. No case occurred of a second elevation of temperature after its return to normal.

Malaise.

The absence of any severe constitutional disturbance was a feature of this epidemic. Four patients only complained of any malaise. In the cases in which it did occur, this was one of the first symptoms, being present almost at the onset of any joint disturbance. It was not of long duration and had disappeared within the first thirty-six hours.

Rash.

The exact number of patients in whom a rash developed is not known, as quite a number presented themselves with the disease in a well-developed stage. Of these, however, several stated that they had noticed a cutaneous eruption before the pain developed; but as it had disappeared quickly they had thought nothing more about it. In three men who were under observation early in the course of the illness, papular eruption developed. This

was first noticed some twenty-four to forty-eight hours after the onset, and in each case it had disappeared without desquamation by the fourth day. The distribution was general, the limbs, trunk and even palmar and plantar surfaces being affected. In one case the rash appeared on the face. No vesiculation and practically no irritation was experienced from this eruption. These three patients were all febrile when the exanthem appeared.

Lymphadenitis.

The majority of patients, whether suffering from either the mild or the more severe forms of the condition, were found to have some degree of tenderness of the lymph glands, especially those in the axillary and inguinal regions. A number of these patients, in addition to the tenderness, had discrete, firm enlargement of these glands. This tenderness and swelling normally had gone by the seventh day; but two men still had firm, painless enlargement of the lymph glands three weeks after their discharge from hospital.

Differential Diagnosis.

Dysentery.—One only of the patients suffering from acute polyarthritides gave any history of diarrhoea within the few weeks prior to its onset. In the area in which the outbreak occurred, gastro-enteritis is probably the most common epidemic disease; but for several months prior to the appearance of the polyarthritides the only cases of gastro-enteritis which had been encountered were amongst transit personnel, and of these there were merely one or two. Also the clinical features of acute polyarthritides, and its rapid and relatively benign course, are evidence against a dysenteric origin.

Dengue.—Although dengue is at times common in areas further north, it is not frequently seen in the locality in which this epidemic occurred. No confirmed case of dengue had occurred here for more than twelve months before the appearance of the polyarthritides. The joint manifestations of dengue, when they do occur, although subject to wide variation, do not resemble those described as typical of this condition. Swelling of the affected joints, a feature of the more severe cases of polyarthritides, does not occur in dengue. The severe constitutional disturbance, high and "saddle-backed" temperature curve, backache, pains in the head and leucopenia, which are all frequently present in dengue, have not been described in any case of acute polyarthritides. The constant nature of the exanthem of the latter condition also differs from that seen in dengue, which is subject to wide variation.

Acute Rheumatic Conditions.—Differentiation from acute rheumatism is normally not difficult, in view of the epidemic nature of the condition and its typical syndrome. In an isolated case, however, some difficulty may occur in excluding rheumatoid arthritis. The clinical history, together with the absence of the more severe manifestations and pathological changes, is of considerable help in this regard. Before the epidemic described by Horan and Halliday occurred, an occasional sporadic case had been encountered, and it was at first believed that these were due to a rheumatoid condition. Later events and pathological investigations seemed to clarify the position, at least to some extent.

Treatment.

Rest, counter-irritation and adequate sedation were found to be the most satisfactory therapeutic measures. Salicylates were of very little value; it is doubtful whether they were at all effective in allaying the pain in the early stages. The application of heat to the affected joints produced relief from pain.

After the acute stage had passed, the patients were encouraged to take as much exercise as possible. It was found that those who followed instructions in this regard suffered considerably less stiffness and limitation of movement during convalescence.

Discussion.

It seems probable that the cases reported in this paper constitute an epidemic of the acute polyarthritides originally described by Horan and Halliday in 1943. In November,

1944, a similar outbreak was reported by E. W. Sibree amongst military personnel in Queensland. In both these epidemics, as in that now described, the more severely affected patients presented a definite syndrome of papular or maculo-papular rash, painful swelling of the joints, mild fever and some tender enlargement of the lymph glands. The absence of any severe constitutional symptoms was also recorded by the former writers.

The outbreak occurred in an area some 300 miles south of Darwin and relatively isolated. The population affected were personnel resident in the area, and not transients. Some six weeks beforehand, in the Darwin area, several cases of what was at first believed to be dengue were recorded; but as the condition developed it was considered that these also were cases of acute polyarthritis. A number of other cases were also reported from scattered units at irregular intervals, but no other epidemic occurred at this time.

In the other units located in the vicinity of that in which the outbreak occurred, an occasional mild case was reported. Only one moderately severe case was encountered, but some doubt remains as to the established diagnosis in this case owing to the existence of a history of previous rheumatic infection.

The outbreak commenced suddenly, 34 cases developing within the first ten days. All 51 had been recorded within thirty-one days, and after that no further cases occurred.

The epidemic nature of this condition is difficult to explain. A close investigation of messing, housing and working conditions gave no clue. Frequently it was found that of four occupants in one hut, who of necessity spent many hours in close company, only one would succumb to the illness, the remainder escaping altogether. This was also found in reviewing the cases in the light of messing, working and other hygienic conditions.

The possibility of this being an insect-borne disease was considered, but no definite indications were found. Although a few mosquitoes were found about the area, these were mainly of the culicine variety, and no mosquito-borne diseases have been encountered. Ticks, mites or sandflies were not seen. A fact of some possible significance seemed to be that three weeks before the occurrence of the first cases of this illness, there appeared in the area large numbers of a variety of fly which inflicted painful and persistent stings. It is understood that this is known as the March fly. When the fly is killed, its abdomen is found to be filled with blood. Practically everyone in the locality suffered bites from those flies, some so severely that it was impossible for them to continue work while the cutaneous reaction was present.

No definite association between the bites of this insect and the development of polyarthritis was found, although the possibility was considered, in view of the sudden appearance and equally sudden disappearance of the insects, and the rapidity of onset of the epidemic. It is interesting to record that the same possible association between the disease and the biting fly was mentioned by Nimmo.

All former writers report wide variation in the severity of their cases, and it would appear that while the condition in its complete form is characterized by the syndrome described, many patients suffering from the disease merely display one or two manifestations. In this regard, some degree of painful limitation of joint movements with lymphadenitis would appear to be the most frequently encountered. The prognosis is apparently good. The only possible fatality recorded is by Horan *et alii*, the patient being a man who developed acute encephalomyelitis after a syndrome closely resembling this condition, two months after the appearance of the first symptoms. None of the patients described in this report showed any sign of cerebral complications.

Unfortunately, detailed special examinations were not practicable at the hospital in which the present series were treated. A number of leucocyte investigations were performed, and resulted in every case in normal figures, without significant change in the differential count. In forty cases investigated at varying periods of the illness, Halliday and Horan report figures varying from 5,000 to 15,000 per cubic millimetre with no abnormal differential

count. These writers also carried out a number of blood sedimentation rate tests, and found that in the active stage of the disease an increase was usual. They make the following statement: "With all its limitations, repeated estimation of the blood sedimentation rate proved to be of considerable value in the management of these cases. This was particularly so in the earlier period when difficulty was experienced in assessing the significance of the later complaints of joint pain and stiffness. With a return to normal readings active movement was encouraged."

Summary.

1. An epidemic of 51 cases of a condition typically characterized by a syndrome of papular rash, painful swelling of several joints, lymphadenitis and mild pyrexia is reported.

2. It is considered that this condition was identical with the acute polyarthritis previously described by Nimmo, by Halliday and Horan, by Sibree and by Dowling.

3. In the cases recorded the clinical picture displayed little variation from that described by the previous writers.

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SURGICAL BALLISTICS.

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FIREARMS were first used as military weapons about A.D. 1400. These primitive weapons were of comparatively large bore and fired a spherical ball, which was propelled by the ignition of black powder. Though they had many disadvantages, at short range they were very lethal. Military requirements demanded increased range, greater accuracy, and a more rapid rate of fire. These have been achieved by increasing the ratio of the explosive charge in proportion to the weight and size of the bullet, by streamlining the bullet, by rifling the barrel to make the bullet spin on its long axis to keep it steady, and by various mechanical refinements. Chemical research has provided new and more efficient explosives, and the introduction of breech-loading mechanism and cartridges has given standard bullets matched with standard charges of explosive, so that the performance of all cartridges of a particular type is uniform. More powerful explosive charges demand that the barrels, especially at the breech where the explosion takes place, shall be considerably strengthened, and in general the result of progress have been increased muzzle velocity, shorter barrels and smaller bores.

The present-day British service rifle fires a charge of 375 grains of cordite, which propels a bullet of 174 grains through a barrel of 25 inches in length which it leaves with a velocity of 2,460 feet per second. The spiral grooves in the barrel or "rifling" impart a spin of 2,950 revolutions per second.

It might be thought that the bullet would, on leaving the weapon, follow exactly the direction in which the long axis of the barrel was pointing at the time of discharge, except for the tendency to fall on account of the action of gravity. The question is, however, far more complicated. The bullet is driven along the barrel by the pressure of the gases produced by the burning of the explosive, in much the same way as the piston of an engine is moved

by gas pressure. Before the bullet leaves the barrel, its direction tends to be changed by phenomena known as "flip" and "jump". By "flip" is meant an actual momentary bending of the barrel caused by the explosion; its direction is usually upwards, and though the effect is small, it is definite and measurable. "Jump" is a movement of the entire weapon, and is caused by the shock of the explosion which acts on the inertia of the weapon—not coinciding with its centre of gravity. "Flip" and "jump" are compensated for in the designing of the sights. When the bullet leaves the muzzle its course is slightly parabolic, with the convexity of the curve upwards; but the curve becomes progressively more pronounced towards the end of its flight. Its velocity is reduced by the resistance of the air through which it passes, and its downward inclination is due to acceleration brought about by gravity. The combined action of these forces forms a resultant acting on the centre of gravity of the bullet. A lateral movement may be imparted by a cross wind, and "drift" is a lateral movement in the same direction as the spin and caused by the spin, its extent being about one foot in one thousand yards. As the bullet leaves the muzzle, the escaping gases following behind may cause the bullet to oscillate slightly; but this effect disappears, and since the diameter of oscillation is small and the spiral is long, it is of no practical importance, and the flight of the bullet may be taken as steady in the initial and proximal parts of its course. Bullets do not wobble when they leave the muzzle, as is so often incorrectly stated in surgical writings.

In the final part of a bullet's flight, when it begins to lose velocity considerably, its tendency to unsteadiness becomes more pronounced, especially in the case of the more modern pointed bullets, in which the centre of gravity is nearer the base than in blunt-nosed bullets.

Bullets which have become unsteady tend to "keyhole" on striking a flat surface. Bullets may be deflected by slight obstacles such as a hayfield or scrub, especially pointed bullets; hence some sportsmen shooting amongst scrub prefer to employ a weapon which fires spherical balls. However, deformed, ill-designed and badly manufactured bullets may wobble seriously in any part of their flight.

The Wounding Effect of Bullets.

The wounding properties of a bullet depend primarily upon three features—weight, design and velocity at the time of impact. Of even greater importance, however, is the nature of the part of the body struck. A high-velocity bullet may kill a man outright instantaneously, while on the other hand the effect may be so slight that in the excitement of battle the wound may not be noticed until some time afterwards. A rifle bullet may pass through the muscles of a limb or even through the chest or abdomen and do comparatively little damage, especially if it damages no large blood vessels or nerves. This is because it retains most of its energy, which is subsequently dissipated on the next object struck. In such cases one finds a small entrance wound with inverted edges and an everted exit wound, which may be of the same size or larger. It is rare to find an entrance wound larger than the exit wound, and this occurs only at short ranges—that is, a few inches—when the gases from the weapon follow the bullet and "blow" the wound open; in this case powder marks may be found on the surrounding skin and in the tissues. However, modern bullets have a tendency to turn over immediately after impact, and this is far more pronounced in the case of sharp-pointed bullets. The result is that the bullet may leave the part approximately sideways and tear a huge gaping everted wound; this is often described as an "explosive" effect. If a bone is struck, the effect may be even more pronounced, since the bone is fragmented and the pieces are energized and act as secondary projectiles; moreover, the skeleton conducts the shock of impact. The great immediate shock and high mortality rate in the case of gunshot wounds of the femur need no emphasis.

As a rule more immediate shock is caused when the bullet traverses solid structures like muscles or the liver than when it traverses less resistant structures like the lung or bowels, provided no large vessels or other impor-

tant structures are damaged. The most effective sites for wounding are well known to the sportsman, whose aim in hunting animals, especially dangerous game, is to cause instant death, or failing that, rapid death. In skull and neck shots he aims at destroying the vital centres; in the shoulder shot he inflicts great bone and muscle damage and possibly injures the heart as well. The kidney shot damages highly vascular structures and possibly the spinal column and cord as well, and in the case of a retreating animal the anus is aimed at and a large number of structures are injured. In the case of soft-skinned animals the sportsman often employs plain lead or various types of expanding bullets, which "mushroom" or otherwise become deformed or broken up to augment their wounding properties. Though accepted as justifiable in hunting, the use of bullets of this type, often termed "dum dum" bullets, is contrary to the accepted ethics of warfare and is expressly forbidden by the Geneva Convention.

After impact a bullet may change its direction, and if an imaginary line is drawn between, for instance, a clean entrance and exit wound, it does not necessarily coincide with the path of the bullet, nor does its projection necessarily indicate the precise direction from which it was fired. Not only is this of medico-legal importance, but it explains many of the bizarre effects sometimes noticed. For instance, a subject who had sustained a through-and-through chest wound was examined; the bullet had entered over the heart and left in the vicinity of the inferior angle of the left scapula; yet none of the intrathoracic organs apparently suffered damage.

The behaviour of human skin is curious. It has considerable toughness and elasticity and offers much more resistance than is generally supposed. Entrance wounds are usually smaller than the calibre of the bullet which inflicted them. Members of the legal profession or the police, unaware of this fact, sometimes request the pathologist to state what type of bullet caused a particular wound in instances in which the bullet itself was not recovered. In a recent case a man was killed by a charge of buckshot. There were 15 perforations in a four-inch group above the left nipple, and examination showed that some had passed through the ribs and vertebral column, while others had traversed soft parts only. That is to say, their velocity had been damped by varying amounts; yet 16 pellets were found in a ten-inch group all immediately under the skin of the back.

Every sportsman knows that a high-velocity bullet can cause instant death without any of the so-called vital organs necessarily being injured, and the degree of certainty with which immediate death can be produced depends principally on the product of the weight of the bullet and its velocity at the time of impact.

There have been many controversies over the relative merits of weight *versus* velocity. Sportsmen are familiar with the so-called "pole-axing" properties of certain high-velocity rifles, which cause an animal to be "dead before it touches the ground". The difficulty is to explain the mechanism, and one can only speculate. It is clear that violent mechanical shock can cause immediate death. For instance, a blow on the head from some blunt object may kill the victim instantaneously; yet in many of these cases the most searching examination is said to reveal no gross changes to the naked eye or histologically. Recently, however, the studies of Windle, Groat and Fox (1944) have thrown some light on the subject of concussion in laboratory animals. Their careful histological studies have demonstrated changes in the neurones of both the brain and the spinal cord. Pole-axing, as practised in modern abattoirs, consists of delivering a heavy blow behind the occiput by means of a blunt spiked pole used like a spear from a platform above. Possibly bullet shock is transmitted to structures at the base of the brain by simple conduction, and this is perhaps the reason why wounds involving the skeleton or solid organs are more often immediately fatal than others. Perhaps there is no great actual difference between bullet shock and pole-axing. Death following after an interval subsequent to receipt of the wound is not the same.

Though much more is to be learnt about ordinary wound or "surgical" shock, the pathology is now fairly well understood, and such wound shock, though often amenable to treatment, may also be rapidly fatal. It is scarcely necessary to add that gunshot may also result in instant death, hæmorrhage or subsequent infection, and that death may be due to a combination of these factors. Probably the only means of causing certain instantaneous death is to destroy the medullary centres. Recovery after fairly severe gunshot wounds of the brain or heart is by no means unknown, and even after a severe and fatal wound consciousness may occasionally remain sufficiently long for the victim to fire back at his adversary or to make a statement.

Types of Weapon and Ammunition.

Various types of weapon may for surgical purposes be classified according to the ammunition they fire. The foregoing remarks apply principally to rifles. Machine-guns inflict the same wounds, but they are more often multiple. Tracer bullets may contain phosphorus and cause burns or phosphorus poisoning by absorption.

Pistols are commonly of rather larger bore than military rifles. The bullet is short and blunt-nosed, and its velocity is comparatively low. However, pistols are used at short range, and by the time the bullet strikes it has not lost much of its original muzzle velocity, as is the case with rifle bullets, which may have lost two-thirds or more of their original velocity before inflicting a wound. The old 0.45 service revolver used to fire a plain lead bullet which was very lethal, as these bullets "mushroom". Cased bullets are now used; but this weapon is going out of vogue in favour of those of smaller bore. The modern Russian Nagant revolver is of small bore, and a powerful charge fires a tapered, square-nosed bullet. Many automatic weapons, such as the Thompson and Sten guns, fire pistol or pistol-type ammunition and for practical purposes may be regarded as pistols rather than as rifles, which they more closely outwardly resemble.

The aeroplane cannon is a new development peculiar to the present war. These cannon are automatic and have a bore of about one inch and a muzzle velocity of about 3,000 feet a second. A variety of projectiles have been used, but four types are in common use: high-explosive, armour-piercing, incendiary and tracer. Gruesome wounds may be seen in victims struck by these shells. Artillery pieces now fire mainly high-explosive shells. In former years more use was made of field guns as antipersonnel weapons. Grape-shot, canister and shrapnel were used for this purpose. The shrapnel shell contained a number of round lead bullets, and on the bursting of the charge the head of the shell was blown off and the bullets were projected. Wounds were inflicted by shrapnel bullets. It is wrong to speak of a wound inflicted by "a piece of shrapnel". The name dies hard, and soldiers call any piece of high-explosive shell or bomb which has produced a wound "shrapnel". Italians use the more accurate term "*scheggia*" (splinter or chip). High-explosive shells and aerial bombs may cause death by "blast" alone.

The fragments of shells and bombs vary in size and may have terrific initial velocity, possibly treble that of a rifle bullet. As the specific gravity is much less than that of lead, and as they are not streamlined but irregularly shaped, the velocity is soon lost. They are dangerous in virtue of their size, their irregularity and sharpness and their ability to drive fragments of clothing, dirt and other infective material into the depths of the wound. They cause rather more tearing than bullets, and often result in damage to arteries and nerves. Small fragments do not usually penetrate far, their energy being damped by the resistance of the skin, and they are comparatively benign. Many bomb and shell fragments are hot enough to become virtually sterile and need not be regarded as highly infective unless they have carried in extraneous material. In fact, it is often surprising what dirty pieces of metal can sometimes be recovered from healed wounds. Some of the smaller hand grenades are dangerous only at short distances, and many of them break up into small pieces which cause annoying and incapacitating multiple wounds

of no great severity. Some grenades and mines are made of "Bakelite" or other non-metallic materials, which are not readily shown by X rays. In modern warfare most wounds are caused by bullets made of lead encased in a shell of some harder metal or by pieces of steel. It is curious that Nélaton's probes, which are designed to detect lead, are still so lavishly provided in some military hospitals.

It has been stated that the Germans have used wooden bullets which may escape X-ray detection. These not only readily break up, but cannot possibly have any great range or accuracy, and reports of infliction of wounds by them are probably quite exceptional if not mythical.

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Reports of Cases.

OPERATION FOR BELL'S PALSY BY COMPRESSION AND INCISION OF THE SHEATH OF THE FACIAL NERVE.¹

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THE following case of Bell's palsy will be of interest in view of the fact that a good result has been obtained by operation.

Clinical Record.

A male patient, W.B., aged forty-four years, was referred to me on April 8, 1946, for opinion and treatment if thought advisable. The patient gave the following history. An accident had occurred on December 5, 1945, when he was kicked and hit on the right side of the head. He fell to the pavement and remembered very little of the assault. He complained of headache and of deafness of the right ear.

Examination revealed complete lower motor neurone paralysis of the right facial nerve. In the right ear, the tympanic membrane was normal, the external canal was normal and there was no evidence of hæmorrhage. The response to the Weber test was noted only in the left ear. Tuning forks C1 and C4 were barely audible. The Rinne test produced a positive result. The voice was not heard at the ear. The left ear was normal.

As general and local therapeutic measures had not relieved the palsy, stimulation of the facial muscles by faradic current was made to reveal whether degeneration of the axones had occurred. The faradic stimulation produced no response; this proved Wallerian degeneration present. Responses to the galvanic current were obtained. Operation by decompression and incision of the facial nerve sheath was recommended and performed on May 23, 1946.

The latest examination of the patient on August 14, 1946, revealed a remarkable improvement in all facial muscles. The tone of all muscles was good. There was no drooping of the right side of the mouth. The patient could smile and show his teeth. The facial expression was satisfactory. Closure of the right eye was incomplete, and the patient was unable to raise his right eyebrow; the tone of the *musculus orbicularis oculi* and *musculus occipito-frontalis* was less than that of the other facial muscles; the partial closing of the right eye indicated that some stimuli must be reaching *musculus orbicularis oculi*, and it is hoped that full function will be restored. This also applies to the *musculus occipito-frontalis*.

The patient had massage and electrical stimulation of the facial muscles for one month after the operation.

¹This patient was shown at a meeting of the New South Wales Branch of the British Medical Association on September 19, 1946, at Sydney Hospital.

Indications and Choice of Time for Operation.

The late Sir Charles Ballance and his co-worker, the late A. B. Duel, in their report⁽¹⁾ following their investigation and work on the facial nerve, recommended in all cases of Bell's palsy, decompression and incision of the facial nerve sheath in the Fallopiian aqueduct. In cases involving the geniculate ganglion, exposure of the facial nerve from the stylo-mastoid foramen to the geniculate ganglion is indicated. As the facial nerve suffers violent toxic infection resulting in inflammatory reaction with compression within the Fallopiian aqueduct, decompression of the vertical part of the canal becomes necessary. To quote Ballance and Duel's words: "The accepted time to operate is now. No delay is justified. The patient has a facial palsy."

Ballance maintains that careful attention to response to the faradic current will allow differentiation between simple cases and those which are severe and in which partial or complete palsy persists. In no case in which response to the galvanic current is absent should operation be performed. If faradic contractility has long been lost, no one can foretell the degree of recovery of the patient.

To sum up: in all cases of Bell's palsy, stimulation is indicated at frequent intervals by galvanic and faradic current in conjunction with local and general therapeutic measures. Persisting palsy or the appearance of Wallerian degeneration revealed by the absence of the response to faradic stimulation calls for operative treatment. When the lesion is in the geniculate ganglion, if the absence of response to the faradic current persists, a decompression operation is to be performed without delay. Patients with involvement of the geniculate ganglion have recovered without operation.⁽²⁾

In a case of Bell's palsy of fourteen days' duration reported by J. B. Horgan,⁽³⁾ response to faradic stimulation was absent. A decompression operation was followed by complete recovery.

Tumarkin⁽⁴⁾ reports his findings and advises close observation of patients and immediate operation on the appearance of the reaction of degeneration.

Sanders⁽⁵⁾ reports a case of loss of response to the faradic current in four days, the nerve being still viable. Recovery followed operation.

Duel⁽⁶⁾ reports a case of Bell's palsy of ten years' duration; recovery followed a decompression operation.

Watykin Thomas⁽⁷⁾ advises a delay for two months for regeneration, but a watch on the responses to stimulation of the muscles.

Operative Technique.

A complete radical mastoidectomy is performed, the mastoid antrum and aditus being widely exposed to permit a good inspection of this region. The facial ridge is removed to give adequate room for the approach to the Fallopiian aqueduct in its course from the floor of the aditus to the stylo-mastoid foramen. To localize the Fallopiian aqueduct, all cells must be exenterated for the entire length of the mastoid bone from the lower margin of the aditus to the mastoid tip, the tip being excised at the same time and the facial nerve exposed on the under surface where it makes its exit from the foramen. The Fallopiian aqueduct, from the foramen to the floor of the aditus, where it bends beneath the lateral semicircular canal, follows a straight path in the bone.

To expose the Fallopiian aqueduct, carefully chisel fine laminae of bone from the foramen to the floor of the aditus. The canal is slightly posterior to the facial ridge in its length. Prior to the chiselling of the final layers of bone, the Fallopiian aqueduct appears as a fine line. The upper end bends antero-medially in the floor of the aditus immediately below the lateral semicircular canal towards the upper region of the promontory to the geniculate ganglion. This is the upper limit of the exposure. When the final laminae of bone are removed, the facial nerve will bulge out of the canal. This permits the incision of the facial nerve sheath by a Gräfe cataract or tenotomy knife, from the stylo-mastoid foramen to the upper limit of the exposed aqueduct. The nerve protrudes through the slit sheath in a striking fashion, more especially if it has been subjected to considerable compression due to

injury or infection. No packing is used in the cavity. The incision is closed with interrupted silkworm gut sutures; a small drainage tube is inserted at the distal end of the incision and remains *in situ* for forty-eight hours. The wound may be treated to prophylactic dusting with sulphanilamide powder prior to suture.

Before the localizing of the Fallopiian aqueduct is commenced, it is essential that all bleeding points should be ligated, otherwise the exposure of the aqueduct becomes difficult. After the exenteration of all mastoid air cells, there is little hæmorrhage from the bone over the Fallopiian aqueduct. This fact gives a dry field and facilitates the operation.

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FATAL HEPATITIS ASSOCIATED WITH TROPICAL LICHENOID DERMATITIS.

By L. C. LUM,
Adelaide.

BOTH the skin condition known to army medical officers as tropical lichenoid dermatitis and infective hepatitis have been common in the South-West Pacific area; it is therefore to be expected that both diseases will occasionally occur in the same subject. However, in the case here reported the onset of symptoms attributable to hepatitis coincided strikingly with the appearance of the dermatosis, and the idea of a common ætiology was therefore entertained. Concerning this association and the probable causative role of "Atebrin", the remarks of Livingood and Dieuaide⁽¹⁾ (Medical Consultants Division, Office of the Surgeon-General of the United States Army) are of interest. They make the following statement:

In rare instances aplastic anemia, other severe blood dyscrasias (such as agranulocytosis) and severe acute hepatitis have occurred in association with the lichenoid-eczematoid syndrome and with exfoliative dermatitis. Similar cases have also been observed rarely in persons taking atabrine who do not develop skin disease. Attention is called to the fact that the fatality rate in these cases of aplastic anemia and of hepatitis has been almost 100 per cent. The relationship between this condition and the skin disease is not clear, but the association is striking. (As regards hepatic disease, in areas where infectious hepatitis is common the exclusion of this infection may be extremely difficult.)

Clinical Record.

Sergeant E.L.W., aged forty-three years, was admitted to an Australian general hospital in the South-West Pacific area on August 18, 1945. He had been taking suppressive "Atebrin" for at least six to nine months (there is no record of the exact period) at the usual dosage of 0.1 gramme per day. He had been perfectly well until three weeks previously; then nausea and occasional vomiting occurred, and he began to suffer from flatulent dyspepsia with much belching of wind. At the same time a rash developed on the legs and shortly spread to involve the buttocks and arms. Yellowness of the eyes was noticed, but was disregarded, since the patient thought it was due to "Atebrin". These early symptoms continued. After a week he noticed abdominal distension, which varied some-

what from day to day and was partly relieved by the passage of flatus. The appetite was lost. The bowels were acting regularly; there was no urinary disturbance. Three weeks after the onset of the illness he reported sick and was sent to hospital. Nothing relevant was found in the previous history; he had had no contact with any known liver poison and he had never had any dyspeptic symptoms prior to the onset of the present illness. His diet had been the standard army ration during the preceding five years. Before that he had taken meat in only small amounts, but it was not thought that this could have any bearing on the present illness.

On examination the patient was a middle-aged man in no distress, making light of his complaints. His temperature was 99° F., his pulse rate was 120 per minute and his respirations numbered 12 per minute. There was a diffuse, generalized, earthy-grey pigmentation of the skin, with typical lesions of tropical lichenoid dermatitis on the legs, buttocks and arms. Pigmentation and "Atebrin" staining masked any jaundice of the skin, but the eyes were deeply icteric. The pupillary reactions were normal. No abnormality was detected in the mouth, throat and neck. The heart action was rapid (120 per minute), but no other abnormality was found. The blood pressure was 150 millimetres of mercury (systolic) and 80 millimetres (diastolic). The percussion note was impaired at the base of the right lung, but the lungs otherwise were clear. The area of liver dullness was increased upwards anteriorly to the fourth intercostal space. The abdomen was grossly distended, and shifting dullness revealed the presence of free fluid; but the liver could not be palpated. There was slight pitting oedema of the ankles; the ankle and knee jerks were normal and sensation was unimpaired. Rectal examination revealed no abnormality. The faeces were light, but not clay-coloured. A ward test of the urine gave a strongly positive result for the presence of bile; no other abnormality was noted.

The initial laboratory studies, which became available during the next two days, gave the following results. On August 19 microscopic examination of the urine revealed triple phosphate crystals and scattered epithelial cells; Fouchet's test for urinary bilirubin gave a strongly positive reaction.

On August 20 a blood examination gave the following information. The serum bilirubin content was 12 Van den Bergh units. The qualitative Van den Bergh test produced a delayed biphasic response. The plasma protein content was 6.2 grammes per 100 millilitres. The haemoglobin value was 16 grammes per 100 millilitres. The red cells numbered 4,900,000 per cubic millimetre and the haematocrit reading was 48%. The white cells numbered 13,200 per cubic millimetre. The mean corpuscular haemoglobin content was 33%. Of the leucocytes, 94% were neutrophilic cells, 0.5% were basophilic cells, 4% were lymphocytes and 1.5% were monocytes; no eosinophilic cells were present. In a film the majority of the red cells appeared larger than normal and were well filled with haemoglobin, but no macrocytes were seen. A pronounced polymorphonuclear leucocytosis was present; many of these cells showed degenerative changes with vacuolation and five or six lobes to the nuclei. A few band forms were seen, but these appeared fragile.

An X-ray examination of the chest revealed elevation of the right side of the diaphragm, the lung fields being clear.

On August 20 a marked and progressive deterioration commenced. This was approximately three weeks after the onset of symptoms. Vomiting was troublesome, and an increasing drowsiness contrasted with the patient's earlier alert and cheerful demeanour. Drowsiness had deepened to semicoma by August 22, while the abdomen became more distended and the area of liver dullness decreased. The twenty-four hour volume of urine was diminished; exact measurements could not be made, since the patient was at this time incontinent of urine. In the hope of promoting renal elimination, 300 millilitres of concentrated serum were given intravenously, followed by a slow, continuous infusion of one litre of a 10% solution of glucose in saline solution and later by the continuous infusion of a 5% solution of glucose in saline solution. The urinary

output thereafter improved and large quantities were passed into the bed.

Further laboratory studies gave the following results. On August 21 microscopic examination of the urine revealed a heavy deposit of amorphous urates, but no other abnormality. The test for urobilinogen gave a strongly positive reaction and Fouchet's test for bilirubin also gave a strongly positive reaction. Hay's test produced a negative result. On August 22 microscopic examination of the faeces revealed no cysts or cells and no ova; the benzidine test for occult blood gave a strongly positive reaction. On the same day no malaria parasites were seen in a blood film, and the blood urea content was 70 milligrammes per centum.

On August 23 generalized muscular twitchings commenced; the patient became deeply comatose, developed signs of terminal bronchopneumonia, and died at 3 a.m. on August 26. He had had throughout a low-grade pyrexia (temperature up to 100° F.) and this increased to 102° F. just before death. No obvious subcutaneous, renal or intestinal hemorrhage occurred.

Other investigations gave the following findings. On August 23 no malaria parasites were seen in a blood film and the Kline test produced a negative result. On August 24 the blood urea content was 85 milligrammes per centum. In a blood film no malaria parasites but numerous reticulocytes were seen. The white cells numbered 12,800 per cubic millimetre; 90% were neutrophilic cells, 6% were lymphocytes and 3.5% were monocytes; no eosinophilic or basophilic cells were seen. Many of the polymorphonuclear cells were young forms; some contained toxic granules.

The total duration of the illness was four weeks, and death took place nine days after the patient first reported sick. The clinical picture, as observed in hospital, was that of acute liver insufficiency. Therapy was mainly supportive, with glucose and saline solution given intravenously and vitamin K and vitamin B₁ administered parenterally.

Autopsy Report.

The positive findings at the post-mortem examination made by Major E. F. L. Laurie, pathologist attached to the hospital, were as follows.

In the abdomen approximately three litres of clear, deeply bile-stained fluid were present. The liver was about one-third normal size and had a somewhat lobulated surface in parts, soft and greyish in colour. On section the raised areas were rather yellow and darker areas contained some hemorrhagic areas. The gall-bladder contained two small calculi and much thin, dark bile. The kidneys were of normal size and no abnormality was detected in them.

Sections were prepared from the liver, kidneys and the skin on the left leg affected by lesions. In many areas of the liver, liver tissue with damaged cells was observed. In many cloudy swelling was present and in others necrosis and increased interstitial tissue with commencing fibrosis; the bile ducts appeared to be blocked. The remaining tissue contained no normal liver structure and was composed of fibrous tissue with pronounced regeneration and numerous small, young bile ducts. There were also many areas of hemorrhage. In the kidney severe congestion and some cloudy swelling of the tubules were present. In sections of the skin was seen some thickening of the keratin and epithelial layers; the prickle cells were in parts flattened and elongated. There was no dilatation of vessels in the underlying tissue, but a few round cells were to be seen. The picture resembled that of early lichen planus.

The diagnosis was considered to be subacute liver atrophy.

Discussion.

No evidence is brought forward as to the role of "Atebrin" in the aetiology of this case of hepatitis. The purpose of this report is purely to put on record a case in which rapidly fatal hepatitis developed at the same time as generalized tropical lichenoid dermatitis; the latter condition is generally attributed to "Atebrin". Reports of such cases are rare.

Agress,¹⁰ in an article just to hand, reports five cases of severe hepatitis associated with exfoliative dermatitis, three of which were fatal. From clinical and pathological studies and from patch testing he concludes that "Atebrin" was the causative agent; there were no cases of infective hepatitis among other patients during the series he reports.

Summary.

A case of fatal acute hepatitis associated with tropical lichenoid dermatitis is described. It is suggested that the simultaneous onset of the two conditions may indicate a common aetiology.

Acknowledgement.

I wish to thank Major-General S. R. Burston, Director-General of Medical Services, for permission to publish this report, and Lieutenant-Colonel C. B. Sangster for assistance in its compilation.

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Reviews.

DISEASES OF CHILDREN.

DR. BRUCE WILLIAMSON has produced the fourth edition of "A Handbook on Diseases of Children", a very useful summary of paediatric information for general practitioners, medical students and nurses.¹ Its reappearance alone is an indication of the demand for it, and that demand is easy to understand, as the book is attractive, concise though comprehensive, well printed and illustrated. The coloured pictures of the common fevers and the food charts alone are worth the cost of the book.

The feature of the new edition which is of greatest importance is the up-to-date information on recent advances in therapeutics, such as the uses of penicillin and the sulphonamides in diseases of children. The section on disorders of the blood is exceptionally good, as one would expect when one recalls that the author was associated with Sutherland in the original advocacy of splenectomy in *purpura hæmorrhagica*. Disorders of the endocrine glands are also handled in a masterly manner.

Without intending to be unduly critical, we cannot but feel that the information on infant welfare and dietetics could be made more useful as it is over-simplified for medical readers. The chapter on common skin disorders is not very satisfactory.

Towards the end of the book there is an abbreviated formulary with prescriptions in which a lot of common information is missing, and room could be found for something more useful than the account of the value of whisky and brandy. Nevertheless, in the compass of a handbook Dr. Williamson has done extremely well to be able to include such a lot of valuable information and so many excellent photographs and diagrams.

We can commend the fourth edition to the attention of those who have not come upon the book previously.

RARE DISEASES.

DR. F. PARKES WEBER, the well-known London specialist in rare diseases, has published a choice collection of erudite essays on "Rare Diseases and Some Debatable Subjects".² This delightful little book is a veritable gold-mine of information, though the contents are difficult to describe concisely beyond the statement that they will appeal chiefly

¹ "A Handbook on Diseases of Children: Including Dietetics and the Common Fevers", by Bruce Williamson, M.D., F.R.C.P. (London); Fourth Edition; 1945. Edinburgh: E. and S. Livingstone Limited. 7½" x 4½", pp. 400, with many illustrations. Price: 12s. 6d. net.

² "Rare Diseases and Some Debatable Subjects", by F. Parkes Weber, M.D., F.R.C.P.; 1946. New York and Toronto: Staples Press Limited. London: John Bale Medical Publications Limited. 8½" x 5½", pp. 174, with illustrations. Price: 15s.

to medical consultants and students of genetics and of the problems of development.

Surely there can never have been any medical man who has had his name associated with the definition of syndromes and rare diseases to a greater extent than has Dr. Parkes Weber. He must be a powerful controversialist in the highest circles of medical criticism in the hub of the universe. Even his exactness in nomenclature is breathtaking at times.

In spite of the rich variety of the subjects covered in the one hundred and seventy pages of the present publication, he has deliberately excluded all but studies of developmental dysplasias, hamatomata, nævi and genetic factors.

A close study of the text will amply reward those who are interested to know the essential features of the Ehlers-Dantès syndrome, Weber-Cockayne disease of the feet, the Parkes Weber-Klippel syndrome, Sjögren's syndrome, the Sturge-Kallischer disease, Maffucci's syndrome, Lutembacher's syndrome and hosts of similar rarities.

Whole essays are devoted to subjects such as the nodules and lymph gland enlargement in rheumatoid arthritis, telangiectatic vascular groups (classified into no less than twenty-one groups), varieties of flushing and blushing, subcutaneous calcinosis, macroglossoma, gynecomastia and endocrine tumour of the adrenal cortex, renal diabetes, inborn familial hepatic cirrhosis, arachnodactylia and allied phenomena such as congenital ectopia of lenses.

Towards the end of the book we find essays on the influence of Dr. Sigmund Freud, pigmentation from prolonged use of prescriptions containing silver or bismuth preparations, bounteous nature and over-nutrition, euthanasia, bone and ivory as currency, the urge to collect and finally some epigrams.

It is a pity that this little book is not bound handsomely—in every other way it is a masterpiece. If a practitioner likes good reading matter or desires access to the inner mysteries of Nature's vagaries he should not miss the chance to obtain this book. Its perusal will act as a stimulus to examine patients closely, to make accurate observations, to be correct in diagnosis and meticulous in description and classification. Above all, Dr. Weber has promulgated the view that when a rare experience is encountered by a clinician he should share the rarity with his colleagues. In this way light will be thrown on commoner problems to the greater glory of medicine and the advancement of learning.

ABDOMINAL OPERATIONS.

WITHIN ten years four editions of Spivack's "The Surgical Technique of Abdominal Operations" have appeared.¹ The book has apparently been well received and the reasons for this are obvious. The size is not cumbersome, even though an astonishing amount of detail has been included. The print is clear and very easy to read and is on good strong paper. The diagrams are excellent and numerous. Many grades of surgeon are catered for in the work which deals with the most elementary aspects of the subject as well as with points which will be of interest to those with experience. The historic background is kept well in mind and a large bibliography is appended to each section.

In an effort to make the book comprehensive rather too many methods of performing the same operation are described. This will tend to confuse the young surgeon. The relative merits of each are not always obvious. Sometimes the subject does not deserve the space and trouble. For instance, four methods are described for the operation of gastric fixation, there are a multitude of procedures for ascites, and, with perhaps more reason but not much, one finds too many gadgets for bowel suture and a bewildering number of incisions for opening the abdomen. Gastric plication did not deserve a mention.

Good descriptions of fundamental points of anatomy precede each section. Sometimes these are made to appear much simpler than they are in the living subject. In the description of methods of closure of a fecal fistula difficulties due to local abscess formation and to possible obstruction distal to the fistula are not mentioned.

Australian surgeons will not be impressed with the methods of dealing with hydatid disease of the liver. Formalin is injected after and not before the cyst is aspirated. A very large quantity is used. Complete excision of large cysts is the method of choice, although it is admitted that this is not always possible. Daughter cysts are broken with the finger.

¹ "The Surgical Technic of Abdominal Operations", by Julius L. Spivack, M.D., LL.D.; Fourth Edition Revised; 1946. Springfield: Charles C. Thomas. 9½" x 6½", pp. 723, with many illustrations. Price: \$10.00.

The Medical Journal of Australia

SATURDAY, DECEMBER 21, 1946.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE MEETING OF THE FEDERAL COUNCIL.

AFTER a meeting of the Federal Council it is generally possible to point without hesitation to one subject or group of subjects as calling for special notice by members of the Branches. At the meeting held recently at Adelaide and reported in this issue the notice of motion of the Queensland Branch, brought forward on its behalf by Dr. A. E. Lee, claims special attention. Members of the Branches were prepared for this discussion by the report of the meeting of the Federal Council of last March, by a leading article in the issue of July 6, 1946, entitled "The Federal Council and the Future", and by an article on the constitution and policies of the Federal Council from the pen of Dr. A. E. Lee published in the issue of September 21, 1946. In all discussions on the Federal Council as the sponsor and spokesman of the Branches, we hear recurring mention on the one hand of the need for the reference of certain constitutional and other matters to the Council of the Parent Body and on the other of the extent to which the Federal Council can speak for the Branches in the matter of policy and of its general lack of power to "bind the Branches". Further, the Branches have been reminded over and over again, particularly by the President of the Federal Council and by its General Secretary, that the Parent Body is not only in complete sympathy with the Australian Branches in their hopes and desires, but also willing and ready to make all possible arrangements by which the Australian Branches may govern themselves as part of the general structure of the British Medical Association. It may be useful on this occasion to hark back to basic facts. The fundamental aim of the association is the same now as it was more than a century ago when it was brought into being—the promotion of the medical and allied sciences and the maintenance of the honour and interests of the medical profession. As has been so often emphasized, there is significance and purpose in the fact that science is placed first. In the everyday life of the Branches this is shown by the holding of monthly meetings

at which discussions centre round subjects of scientific and practical value in the prevention and cure of disease as it affects the human mind and body. It is shown every year by the holding of an annual meeting of the whole association at which medical subjects are dealt with in sections comprising the different specialties. The non-scientific activities of the association, conveniently described as medico-political, are discussed with matters affecting the domestic life of the association at the Annual Representative Meeting, which is for practical purposes the parliament of the association. There may be a tendency—and signs of such a feeling have been shown—to look on the Council of the association in London and the Representative Body as being something remote, something separate, from the Federal Council and the Australian Branches, and strangely this idea seems to have been given some colour by the references to the willingness of the Parent Body to allow the Australian Branches every possible freedom of self-government. Those who were present on the occasion will remember how well the real state of affairs was put at a most friendly conference at Melbourne in 1935 between executive officers of the Parent Body and the Federal Council. On that occasion the late N. Bishop Harman, the association's treasurer, speaking on a matter of finance, pointed out that the funds of the association were the funds of the whole body and not of the Parent Body only. As the funds belong to one body, so are the component parts of that body actively joined together as a composite whole. When, therefore, the Federal Council, as it is in duty bound to do, refers certain matters to the Council of the Parent Body, it is consulting, not a superior outside authority, but one of which the Australian Branches form an integral part and in whose control they have a share.

Returning to the Queensland motion which is printed in full on page 874, we remember that the first portion dealing with an alteration in the composition of the Federal Council has been anticipated, if not desired, by some Branch leaders for some considerable time. When the Federal Committee was first formed as a consultative and coordinating body the representation of each Branch by two members was satisfactory. It has repeatedly been said during the past few years in connexion with the idea that the Federal Council should have power to "bind the Branches", that this power should not be given until some increase in the representation of the larger Branches has been made. Conversely the view has been held that the Federal Council has all the power that it needs in respect of Branch control and that for this reason there is no need to alter the composition of the Council. It was probably some opinion such as this which influenced the Victorian Branch to withhold its acceptance of the first part of the Queensland motion. Now, however, that the Commonwealth Government's referendum proposals regarding social services have been accepted by the people, it is thought that the Federal Council may have to undertake some action, and this, as Dr. Victor Hurley suggested, may lead the Victorian Branch to reconsider its attitude. We would point out that it is typical of the Federal Council's efforts to achieve unanimity, that the Victorian Branch will be asked to accept the altered composition of the Council before anything is done in the way of altering the Articles of Association. The proposed alteration in the composition of the Federal Council must in no sense

be taken as indicative of a desire in any quarter to set up any interstate feeling. On the contrary the federal spirit animates the discussions and decisions of the Federal Council to an unexpected degree; differences of opinion are almost invariably due to a difference of conditions which have a geographical or population-density basis. If interstate suspicion or jealousy did find a place in Federal Council deliberations, we should find that the suggested alterations in numbers would be much nearer to a true proportional representation. In regard to the "powers" of the Federal Council there are two aspects to be considered. The first has to do with powers that are at present obtained from the Parent Body; the second is concerned with the acceptance by the Branches of the Federal Council's decisions. Dr. A. E. Lee made this quite clear in speaking to his motion at the Federal Council's meeting. The powers obtainable from the Parent Body are powers of self-government; that they will be granted there is no doubt. The matter is surely little more than a question of convenience, for in these days communication with Great Britain is rapid beyond the imaginings of a few years ago. A Branch secretary in Queensland or New South Wales has very little longer to wait for a reply to a letter sent to London than he has from his opposite number in Perth. And an emissary from the Federal Council could be in London with the Parent Council one week and with the Federal Council in Melbourne in the following week. No one has yet drawn up a list of the "powers" that the Parent Body should confer on the Federal Council. When this is done we shall be surprised if the list is a long one. The question of power as between the Federal Council and the Branches is quite another matter. As the General Secretary has pointed out, the only persons whom the Federal Council can legally "bind" at present are its twelve members. The short account of the discussion on this point at the recent meeting shows the peculiar difficulties of this subject. The resolution to which the Branch Councils will be asked to agree makes procedure a little simpler than it has so far been and will cut short the time that is taken before a final decision is reached. The decisions of the Federal Council in regard to the Queensland Branch's two motions mark a forward development. This is evidenced by another decision that was reached in regard to the position of a Branch which has been financially embarrassed because of its activities in matters affecting the profession as a whole. Here the Federal Council is to display the same breadth of vision and understanding as were shown to it by the Council of the Parent Body when it was in a difficult financial position in 1935 because of problems of organization. This is a point that might well be remembered in connexion with the Federal Council's decision.

The other matters dealt with by the Federal Council include important items. The discussion on tuberculosis was one of these. A movement is on foot for the creation of a National Association for the Prevention of Tuberculosis to cover the whole Commonwealth. This will be discussed on another occasion together with the Federal Council's views. The rehabilitation of ex-service personnel with a disability not accepted as related to war service raised some difference of opinion, not in regard to the need for such rehabilitation, but about the way in which it should be done. The need for a quick decision in this

matter does not require emphasis. Moreover, any refusal to cooperate with the Commonwealth Government in this matter, if refusal there should be, will have to be well founded. The profession must not place itself in the wrong in the eye of the public; it should be within the abilities of those entrusted with this matter to devise means to allay the suspicions of the fearful. For the profession to put itself in the wrong in the public eye is not wise, and this is happening in Queensland by the failure of members to respond to the Repatriation Commission's appeal in regard to its service for widows, orphans and widowed mothers of the 1939-1945 war. That these widows and orphans are in all probability being generously treated by Queensland practitioners (we cannot imagine that they would be otherwise treated) will not matter. To the public the refusal to cooperate with the commission will be an occasion of offence and a cause of reproach in the future. The other points in the report to which we would draw special attention are the progress that has been made with the Federal Common Form of Agreement for friendly society lodge practice, the launching of the Medical Benefits Fund of New South Wales and the views expressed by Dr. F. W. Carter on community hospitals.

Current Comment.

UNEXPLAINED LOW-GRADE FEVER.

THE interpretation of fever as a sign of disease is often difficult. Pyrexia or fever of undetermined origin is a label of some value in military service when patients are being evacuated by stages to medical units where a final diagnosis may be made. In civilian practice the need for a written tentative diagnosis may not be pressing for record purposes, but difficulty often arises in classifying fevers, especially those of the short-term variety. In addition there are cases of a worrying kind in which fever may be observed over a considerable period without the cause being ascertained. When the fever is of a low-grade kind, and there are no striking signs of serious disability, the medical attendant is in a dilemma. He does not wish to overlook anything important, nor does he wish to stress a condition whose prolonged and perhaps fruitless investigation may encourage unwelcome introspection on the part of the patient. Such patients form the subject of an inquiry by E. M. Rappaport, who has collected a series of 25 men investigated in hospital.¹

Most of Rappaport's patients were admitted to hospital because of persistent fever, but in a few instances the condition was discovered during observation for other symptoms. The author admits that their complaints were varied and numerous, without corresponding objective findings, due, as he aptly remarks, to "a pathological preoccupation with somatic sensations to which prolonged hospitalization contributes in no small measure". The symptoms were chiefly exhaustion, loss of appetite and of weight, palpitation and nervousness. No cause for the continued fever was found after full investigation, though the condition persisted for many weeks. The tentative administration of sulphonamides produced no change. A preponderance of neuropathic traits was noticed in these patients, quite beyond such anxiety as might be engendered by an experience of this kind. Several of the patients bought thermometers; whether to check the accuracy of the hospital staff's readings or to derive a melancholy satisfaction from this evidence that they were not as other men, is not clear. There is, after all, a great difference between the realist with, say, pulmonary tuberculosis, who imposes the check of a rise of tempera-

¹ *Annals of Internal Medicine*, July, 1946.

ture on undue zeal in his activities and the introvert who merely worries about it. Two striking features of Rappaport's observations must be noted. The fever in every case had its daily peak at a level between 99° and 100° F. These readings were taken in the mouth, and precautions were taken to make sure that no artefact recording was produced by any device of the patients. The rectal temperatures were also taken repeatedly as a control, and the astonishing thing is that these readings showed no rise above the accepted normal average. It is accepted that the rectal temperature is usually higher than the oral, but in these cases the abnormal readings were invariably confined to the latter. In fact, no constant relationship could be established between the two sets of observations. Rappaport believes that the cause of this anomaly lies in vasomotor instability, perhaps following some brief infective illness in a person whose autonomic system is labile and easily disturbed. If such a psychosomatic state was once established a vicious circle might arise which would not easily be broken after the long strain of an apparently useless sojourn in hospital. The author attaches special significance to the discrepancy between the oral and rectal temperatures which he found in his series, and regards this as a criterion of a benign neurotic state. It would be of interest to analyse a considerable series of similar cases of unexplained mild fever, carrying out brief but adequate investigation and employing strict controls. Observations on the skin temperatures might possibly be of interest, and it might also be helpful to collect a large series of temperature recordings accurately carried out in parallel with an assessment of the psychiatric state of the subjects. Rappaport labels the state he describes as "essential oral hyperthermia", but the name hardly seems apt, since he lays down the principle that the maximum normal mouth temperature should not be arbitrarily limited at 99° F. Still, this is an attempt to explain a certain rather puzzling condition, and also to lay down some positive guides for what is believed to be a neurosis.

THE "NEGATIVE" X-RAY REPORT.

FIFTY years have passed since Röntgen announced the discovery of the rays which bear his name. This half-century has seen the development of radiology into one of the most valuable of the ancillary services to medical and surgical science. However, it must always be recognized that it is but one link in the chain of diagnostic evidence, and can never replace the trained use of our five senses. There is a tendency nowadays to regard the radiograph as the final court of appeal and to accept its evidence against definite clinical findings, negative or positive, the result often being an unreasonable condemnation of a very valuable aid to diagnosis.

Brailsford¹ issues a timely warning in a discussion on the evaluation of the "negative" radiological report. He states that many errors in diagnosis and much delay in treatment are caused by a failure to recognize what he terms "the latent negative radiographic period", or the period that elapses between the onset of clinical signs and symptoms and the appearance of radiological evidence. This is due to the widely adopted impression that the onset of a lesion is immediately associated with the production of radiographic signs of such lesion. Radiographs are but shadowgraphs of the different densities through which the rays pass. For a lesion to be detectable it must have attained a size distinguishable to the naked eye, and it must be of greater or less density than the surrounding tissues. The duration of the latent negative interval varies considerably according to the nature and site of the lesion. Acute conditions such as lobar pneumonia may show radiographic evidence within a few hours, whereas some parasitic cysts may not be demonstrable for years, until calcium has been deposited in them. Probably the most important conditions in this respect are tuberculosis and malignant bone tumours, which are often missed because one or two early examinations producing negative

results have lulled the mind of the clinician into a false sense of security. It is in such conditions that early clinical diagnosis is essential if the prognosis is to be reasonably good. To wait for positive radiographic evidence will often prove fatal. At the other end of the scale Brailsford defines the "positive radiographic symptomless period", or the period after disappearance of clinical signs and symptoms, and during which the radiograph still shows departure from the normal. This is also a period of deception, which lasts a variable time, and in many cases will persist for the remainder of the patient's life. It is a period when two sources of error are possible. First, we have the spectacular appearance of an unsuspected healed lesion, which may lead to much unnecessary interference or investigation. In the second place the latent "negative" radiographic period of reactivity may not be observed in the evidence of a healed lesion, and fresh symptoms may be discounted. This will be especially appreciated in the recrudescence of tuberculosis and osteomyelitis.

These discrepancies between radiological and clinical examination, which are apt to have unfortunate results, can be appreciated only when there is reasonable cooperation between clinician and radiologist, and the evidence of each is correctly correlated.

THE TREATMENT OF PERFORATED PEPTIC ULCER.

ACCORDING to the authors of textbooks the only possible treatment for perforated peptic ulcer is surgical operation. As Bailey and Love put it, "operation, as soon as the general condition permits, is the only course". Attention is therefore arrested by an article entitled "Perforated Peptic Ulcer Treated without Operation". The author is Hermon Taylor, assistant surgeon at the London Hospital, and he bases his remarks on a series of 28 cases.² He points out that in a case of perforation the gravity of the condition depends not so much on the fact of perforation as on the likelihood of fatal peritonitis. Further, the factors which determine the issue—the interval between perforation and treatment, and the amount and character of the leakage from the stomach—vary within the widest limits. "Automatic surgical intervention takes no account of this variation, nor does it recognize the existence of the natural defence mechanism within the peritoneal cavity." Taylor was led to devise his treatment by finding repeatedly when operating on patients with early perforation that the peritoneal fluid was sterile and that he could dispense with drainage. He also found occasionally, as many surgeons have done, that when he opened the abdomen, the perforation was already sealed off by adhesion to a neighbouring viscus. Taylor begins his treatment by giving the patient substantial doses of morphine. The patient's stomach is then emptied by a large stomach tube attached to a gastric suction bottle. The stomach tube is withdrawn and a smaller tube is passed through the nose and fixed in position. The stomach is then aspirated at half-hour intervals with a 20-millilitre syringe. Fluid is administered rectally, subcutaneously and intravenously, the quantity given in each 24 hours being equal to the amount withdrawn from the stomach plus three pints. Small sips may be given, provided they are removed at once by aspiration. Otherwise nothing is allowed by mouth for the first day. On the second day hourly aspirations are followed by drinks of one ounce of water. A mixture of milk and water is substituted on the third day and the tube is removed when the fluid given is passing into the intestine. Of the 28 patients treated in this way, 24 made an uneventful recovery, three died from causes unconnected with the treatment, and one died who might have been saved by immediate operation. All but two of the perforations in the series were duodenal. Taylor's paper is worthy of careful study. The art of surgery lies as much in the avoidance of operation as in its performance. A method such as this would be useful for a practitioner practising in professional isolation, if for no one else.

¹ *The Practitioner*, September, 1946, page 200.

² *The Lancet*, September 28, 1946.

Abstracts from Medical Literature.

GYNÆCOLOGY.

Urinary Incontinence.

ALBERT H. ALDRIDGE (*American Journal of Obstetrics and Gynecology*, March, 1946) describes an anatomical operative approach to the problem of urinary incontinence in fistulous communications between the urethra, bladder or ureters and the vagina or uterus. No operation which includes denudation of tissue should be devised unless tension on the tissues is avoided. For the closure of a fistula, flaps consisting of the whole thickness of the vaginal wall, insuring optimum nerve and blood supply, are most successful. Urinary incontinence can be cured in 80% to 90% of cases by vaginal plastic operations, and if these fail, fascial transplantation operations should be considered.

Carcinoma of the Vulva.

LANGDON PARSONS AND JOE VINCENT MEIGS (*The New England Journal of Medicine*, June, 1946), in evaluating progress and present-day treatment of carcinoma of the vulva, have reviewed recent literature which supports their plea for earlier diagnosis, for recognition of the precancerous stage and for a more radical surgical removal of the vulva and the superficial and deep lymphatic line of spread. The worst examples of delay, mistaken diagnosis and faulty treatment occur in the treatment of carcinoma of the vulva. The elderly patient with *pruritus vulvæ* must be educated to see her medical practitioner promptly, and not to temporize with various ointments, salves and hormones. The practitioner must be alert to the early manifestations of the premalignant state or the actual presence of a cancerous lesion and must be able to recognize the difference between kraurosis and leucoplakia. Leucoplakia is a precancerous lesion in which one-third of the cases proceed to carcinoma and should be treated by vulvectomy. Kraurosis, on the other hand, is an atrophic process and should be treated with oestrogen therapy, vitamin A and hydrochloric acid given by mouth. The association of genital cancer with venereal disease, especially lymphogranuloma, is well known. Tenderness of the local lesion is common and can be a pitfall in diagnosis. The size of the initial lesion is the largest single factor in prognosis. The position of the lesion in relation to the midline is also of prognostic significance. Ulcerating lesions are more prone to distant spread than papillary lesions. All tumours of the vulva should be submitted to biopsy whatever their size or the age of the patient. The normal vulva does not tolerate radiation by X rays or radium, and, moreover, radiation therapy in combination with surgery is ineffective. To use radium or X rays, partial vulvectomy or complete vulvectomy with superficial groin dissection is to court disaster. Cancer of the vulva is a disease of the entire vulva, there is often bilateral invasion of the regional lymph glands in the groin and of the deep femoral chain above Poupart's ligament along the external iliac vein. The surgeon must adopt a more radical approach to the eradication of the neoplasm as regards

both the initial lesion and its distant spread. The technique of the radical operation at Massachusetts General Hospital is described. Treatment of the local lesion is by a wide complete vulvectomy including the perianal skin. The superficial groin dissection is followed by an attack on the lymph nodes below and above Poupart's ligament proceeding as high along the iliac vein or as deep in the pelvis as the surgeon cares to go. This is done without division of Poupart's ligament by a vertical incision and retroperitoneal dissection after the inguinal canal is opened.

The Transmission of Penicillin to the Previæ Fœtus.

JOHN H. E. WOLTZ AND MARJORIE M. WILEY (*The Journal of the American Medical Association*, July 20, 1946) give results of an investigation to determine whether penicillin crosses the placental barrier early in pregnancy. Penicillin is in common use for the treatment of syphilis in pregnancy and in the prevention of congenital syphilis following work done on the placental transmission of penicillin on women at or near term. It is probable that arsenicals do not pass to the fetal tissues prior to the beginning of the latter half of pregnancy, and even then are not always in sufficient amount to cure an already infected fœtus. Penicillin was given to six women about to have therapeutic termination of pregnancy at periods of gestation from nine to twenty-five weeks. Four patients received the drug intravenously and two intramuscularly, and the doses varied from 35,000 to 300,000 units given over periods ranging from one to twelve hours before operation. At operation the fœtus and membranes were delivered intact and specimens of amniotic fluid, heart blood, fetal tissue fluid, cord blood and maternal blood were taken and penicillin concentrations were determined. It was found that penicillin is transmitted to the fœtus as early as the tenth week of gestation. Penicillin probably appears a safe spirocheticide which readily permeates the fœtus at any month of pregnancy and which can be expected if given in proper dosage to cure syphilis in the fœtus.

Preinvasive Carcinoma of the Cervix Uteri.

EDGAR R. PUND AND STEWART H. AUERBACH (*The Journal of the American Medical Association*, July 20, 1946) record a histo-pathological study of "preinvasive carcinoma" in 1,200 whole cervixes removed for causes other than carcinoma. This has prompted observations on the genesis and natural history of carcinoma of the cervix. Preinvasive lesions are now being more frequently found because surgeons and pathologists are searching for the condition. A confused terminology and the failure of cancer to develop from some untreated preinvasive lesions have led to some reluctance in the acceptance of preinvasive lesions at their full value. The authors consider that cells of these lesions are fully neoplastic and will ultimately invade the tissues of the cervix unless eradicated. Preinvasive carcinoma was discovered microscopically in 47 of the cervixes (3.9%); no equivocal cases or invasive cancer were included in the series. The average age of patients with preinvasive carcinoma was 36.6 years, a striking observation when considered

with the accepted age group of 48 years for overt cancer. There appeared to be no association with concurrent pelvic disease such as uterine fibroids or salpingitis. In 80% of the sections there was microscopic evidence of normal cyclic endometrial function. The most obvious gross feature of the specimens was the absence of evidence of carcinoma. The lesions first appeared on the gland-bearing endocervical lining, at or near the external os, and probably arose from the multipotent basal cells. The authors do not concur in the opinion that cells of the stratified squamous epithelium are the customary source of cervical cancer. Some of the areas were entirely discrete and gave the impression that carcinoma may arise simultaneously in more than one focus of the cervix. From the initial focus or foci the growing cells spread vertically and laterally over the endocervical surface and into the glands. Inconstantly the spread is downwards to displace the stratified squamous epithelium of the *pars vaginalis*. After an undetermined period of latency, invasion of the tissue extends into the stroma and actual tumefaction begins. There is usually a further long period before the carcinoma is manifest. It would appear that invasion begins about six years after the preinvasive phase and that frank cancer may be delayed an additional six years before definite ulceration of the vaginal cervix becomes obvious. There is little reason to doubt that virtually all preinvasive carcinomata are curable, but their detection at present is laborious for both surgeon and pathologist.

The Manchester Operation for Uterine Prolapse.

CHARLES A. GORDON (*American Journal of Obstetrics and Gynecology*, August, 1946) reports 206 Manchester operations for uterine prolapse and makes special reference to the advantages of the performance of this operation during the child-bearing period and for complete proclitidia. In this series there were 36 women below the age of forty years and parturition subsequently occurred in ten of these. Details of the subsequent labours of five of these were known, and of the five, four were delivered normally or by low forceps application and one required Cæsarean section for a rigid cervix. Many authorities who prefer the Manchester operation as a routine for prolapse in post-menopausal patients do not perform the operation on women during the reproductive period of life on account of the alleged risks of parturition following amputation of the cervix and repair of the upper pelvic supports. The author does not consider it necessary to amputate the cervix in many cases of prolapse even when complete proclitidia exists and the cervix should not be amputated in the operation for prolapse in patients in the reproductive period of life. His success with the Manchester operation over a period of 28 years and the collected statistics of British, Continental and American workers support the claims of this operation for the cure of prolapse in women during the reproductive period. Recurrences after subsequent childbirth are few, the incidence of forceps delivery is increased and Cæsarean section for failure of the os to dilate is a remote possibility. In 89 patients with complete proclitidia treated by the Manchester operation there were only

two failures. The operation is not only rational for proclitica, but is more readily and expeditiously performed in this type of condition and excellent results are reported by many workers.

Prevention and Treatment of Carcinoma of the Vulva.

B. P. WATSON AND S. B. GUSBERG (*American Journal of Obstetrics and Gynecology*, August, 1946) record a study of thirty patients with carcinoma of the vulva treated by various surgical measures and radiation. The figures, the authors state, are too small for any statistical study, but they are combined with an analysis of the deaths and other recorded cases and certain observations are made. The disease is, in general, one of advanced years; the average in this series was fifty-nine years. The outstanding symptoms were pruritus, a tumour, pain and local discharge. The delay between the onset of symptoms and the commencement of treatment averaged three and three-quarter years. Patients whose chief symptom was pruritus did not commence cancer treatment for an average period of eight years. It is obvious that many individuals in the series had lesions which should have brought them for treatment earlier. Every leucoplakic area which causes constant itching and fissuring should be excised; ointments, hormones and radiation have no place in the treatment of such conditions. Any irritated or ulcerated lesion of the vulva which does not yield promptly to simple therapy should be subjected to biopsy by free excision. Extension of vulval carcinoma into the vagina makes the prognosis extremely grave, and recurrence where treatment has failed usually takes place before the end of two years. Radiation as a form of primary treatment has been discarded. On account of the age of these patients and the frequent incidence of other systemic diseases conservative surgery has a definite place in treatment. A simple wide excision (partial vulvectomy) is not only the best form of biopsy, but will save a small group of patients with low-grade malignant lesions. The routine treatment of choice is complete vulvectomy with bilateral block dissection of the groins. On account of the infrequent involvement of retroperitoneal glands and the considerable operative mortality rate the authors do not favour deep dissection of the external iliac and obturator glands.

OBSTETRICS.

Cæsarean Section.

EDWARD G. WATERS (*The New England Journal of Medicine*, June 27, 1946) draws attention to the lack of unanimity on the indications for Cæsarean section and to the choice of operation and gives the established lines of treatment at the Margaret Hague Maternity Hospital. Elective Cæsarean section for *primipara* with obvious disproportion is undisputed. *Primipara* with the "borderline pelvis" challenge the judgement and experience of the most capable attendant, and even with accurate mechanical and X-ray pelvimetry it is often impossible to decide whether the patient will deliver herself without an adequate test of labour. X-ray pelvimetry is regarded with esteem, but without abject deference, and is valued well below clinical judgement. Cæsarean

section is not indicated in cardiac patients unless there is some other obstetrical complication. Through competent medical care and the elimination of operative interference the incidence of decompensation has been reduced from 22.3% to 2.5% and the maternal mortality from 3.5% to 0.6%. In accidental hæmorrhage after the twenty-eighth week each case must be considered on its merits according to the parity of the patient, dilatation of the os, and the degree of shock and hæmorrhage. All patients with severe pre-eclampsia are treated medically and vaginal delivery is anticipated. Section is resorted to when the toxæmia is progressive or recurrent, or when there are other obstetrical indications. Eclampsia should be one of the rarest indications for Cæsarean section. The operation is not employed if the patient is having fits, but is occasionally done when the convulsive phase has been completely overcome. In hypertension vaginal delivery is the method of choice and results in a lowered maternal mortality. *Placenta prævia* is a recognized indication for Cæsarean section, and the author is emphatic that there is no valid reason for electing to do the classical operation when the lower segment operation is always better and safer. Concerning operative technique, it is time for all obstetricians to learn and to use an acceptable form of lower segment operation and to cease justifying the continued use of the antiquated classical section. Classical Cæsarean section is used only when Cæsarean hysterectomy is being performed. The use of the classical operation for *placenta prævia* is ill conceived on anatomical grounds. In cases of elective Cæsarean section in good risk patients, not in labour and with intact membranes, the lower segment operation should be chosen on account of the lower morbidity, smoother convalescence and lowered incidence of subsequent rupture of the uterine scar. In the treatment of patients who have been long in labour with ruptured membranes the lower segment operation is far superior. Patients with foul intrauterine infections should not be treated by classical or lower segment operation, but by extraperitoneal Cæsarean section. In all septic parturient patients the peritoneal cavity should not be opened. The Forro operation as employed in septic cases is an antiquated operation.

Intrauterine Respiration.

M. EDWARD DAVIS AND EDITH L. POTTER (*The Journal of the American Medical Association*, August 10, 1946) review experimental work on intrauterine respiration of the foetus and report their X-ray and histological findings in the lungs of 26 foetuses and full-term infants following the injection of thorotrast into the amniotic cavity. It is generally believed that the human foetus is in a state of apnoea, and premature attempts at breathing occur only when there is interference with the placental circulation. Previous X-ray examinations of foetuses and newly born infants following the injection of radio-opaque substance into the amniotic sac have given conflicting results by different workers. It would appear that the concentration of thorotrast injected and the time elapsing between injection and delivery are of importance. Experiments were carried out on two groups of patients—the first

comprised sixteen women in the first half of gestation in whom pregnancy was terminated for therapeutic reasons by abdominal hysterotomy. Twelve to forty millilitres of *liquor amnii* were withdrawn and replaced by thorotrast at intervals of thirty minutes to fifty-two hours before hysterotomy. After the uterus was opened the foetus was quickly and carefully removed and submitted to X-ray examination, and the lungs of previable foetuses were later examined histologically for the presence and distribution of thorium. All showed thorotrast in the stomach and intestinal tract. Thorotrast was found radiologically and histologically in the lungs of twelve of the foetuses. The widespread distribution of thorotrast in the bronchi and in the alveolar ducts and spaces is considered indicative of the circulation of amniotic fluid throughout all the lung spaces and not related to operative interference. Histologically, all portions of the pulmonary tree in all lungs had demonstrable lumina and there was no evidence that they were collapsed at any stage. The presence of thorium in equal amounts in all parts of the lungs of twelve foetuses indicated that the amniotic fluid containing thorotrast circulated freely throughout the entire pulmonary tree. The second series of patients were ten women at or near term from whom 24 to 48 millilitres of amniotic fluid were withdrawn and replaced with an equal amount of thorotrast at periods of sixteen to forty-eight hours before Cæsarean section. Thorotrast was shown radiologically in the lungs of five of the infants in these cases. The writers conclude that an aquatic existence of the foetus during intrauterine life is normal and that amniotic fluid freely circulates throughout the lungs from twelve weeks to term. This respiratory activity of the foetus is intermittent, irregular and shallow. At birth air is substituted for fluid and a more sensitive respiratory mechanism is developed resulting in respiratory movements which are deeper, regular and continuous. The general pattern of respiration, however, remains the same.

Therapeutic Abortion.

W. T. DANNREUTHER (*American Journal of Obstetrics and Gynecology*, July, 1946) has reviewed the therapeutic abortions done over a period of ten years at the New York Post-Graduate Hospital. In all 84 abortions were performed, the indications being: cardiovascular disease, 20 cases; psychoneurological diseases, 14; renal disease, 12; hyperthyroidism, 9; tuberculosis, 8; persistent *hyperemesis gravidarum*, 3; and miscellaneous causes, 18. Fifteen out of the twenty cardiac patients submitted to abortion were suffering from mitral stenosis, and six of the twelve with renal disease had chronic glomerular nephritis. In a discussion of the hyperthyroid cases C. G. Heyd stated that there were two groups of patients: (a) the patient already pregnant with hyperthyroidism in whom it is the rule to do a subtotal thyroid resection irrespective of the pregnancy which rarely miscarries; and (b) the post-operative hyperthyroid patient who becomes pregnant within eighteen months of operation and whose pregnancy is better terminated as there is a high incidence of return of hyperthyroidism in this period.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the office of the South Australian Branch of the British Medical Association, 178, North Terrace, Adelaide, on November 12, 13 and 14, 1946, SIR HENRY NEWLAND, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. W. F. Simmons and Dr. H. R. R. Grieve.

Queensland: Dr. A. E. Lee and Dr. H. W. Horn.

South Australia: Sir Henry Newland, C.B.E., D.S.O., and Dr. R. J. Verco.

Tasmania: Dr. C. Craig and Dr. J. S. Reid.

Victoria: Dr. F. L. Davies and Dr. T. E. Victor Hurley, C.B., C.M.G., V.D.

Western Australia: Dr. F. W. Carter and Dr. N. M. Cuthbert.

The New South Wales Branch appointed Dr. H. R. R. Grieve as substitute for Dr. A. J. Collins, D.S.O., M.C.

Minutes.

The minutes of the previous meeting of the Federal Council of March 5, 6 and 7, 1946, which had been circulated amongst members, were taken as read and signed as correct.

Annual Report of the Federal Council.

The annual report of the Federal Council for the year ended June 30, 1946, was received.

Finance.

Dr. W. F. Simmons presented the financial statement and balance sheet as at June 30, 1946. The statement, which included the Federal Council account and the Australasian Medical Congress (British Medical Association) fund account, was received and adopted.

A discussion took place on the capitation rate for the ensuing year. It was resolved that the amount for 1947 should be at the rate of 10s. for every member on the membership list of the Branches as from January 1, 1947.

Dr. W. F. Simmons referred to the Federal National Health Insurance Emergency Fund. He thought that as the need for this fund no longer existed, the money should be transferred to the Organization Fund. He said that there was no legal bar to such an action, and the Branches had already approved of the transfer. The Federal Council resolved to transfer the money to the Organization Fund on the motion of Dr. A. E. Lee, seconded by Dr. N. M. Cuthbert.

Dr. Simmons referred to the Federal Organization Fund. He pointed out that the General Secretary had recently visited England on the business of the Federal Council, and that his expenses had to be met. Some discussion took place about whether the amount should be paid from the Organization Fund or from the general funds of the Federal Council. It was resolved that a sum of £500 should be transferred from the current account of the Federal Council to the Organization Fund, to reimburse that fund for part of the cost of the General Secretary's visit to England.

Medical Officers' Relief Fund (Federal).

Dr. W. F. Simmons presented the report and balance sheet of the trustees of the Medical Officers' Relief Fund (Federal) for the year ended June 30, 1946. He pointed out that the fund was still functioning, and that the total amount of the fund was diminishing. During the previous year the amount paid out was greater than the amount of income, and it had been necessary to call on the capital. At the end of the year in question the amount outstanding on loan had been reduced from the previous year by the sum of £75. The report and statement were adopted.

Federal Medical War Relief Fund.

Dr. W. F. Simmons reported that the Deed of Trust for the Federal Medical War Relief Fund had been completed and registered. The trust was in order. So far no applications for relief had come in. Dr. Simmons pointed out that the amount of the fund stood at £15,107 11s. The amounts subscribed by the Branches to date were as follows: New South Wales, £5,500; Queensland, £1,265 4s. 6d.;

Victoria, £4,075; South Australia, £1,635 0s. 9d.; Western Australia, £399 10s. 6d.; Tasmania, £1,119 6s. 6d. Interest on Commonwealth Treasury Bonds had yielded £113 8s. 9d. Dr. F. W. Carter, in explaining the position of Western Australia, pointed out that the State had its own Protection of Practices Fund, which had been established to provide relief to ex-service medical officers. The amount of this fund was upwards of £12,000. The report was received.

Decorations Received by Medical Officers of the Armed Forces.

The General Secretary reported that on behalf of the President and members of the Federal Council he had offered congratulations to the following members of the Australian armed forces who had been honoured by His Majesty the King: Dr. A. P. Derham, C.B.E.; Dr. L. E. Le Souef, O.B.E.; Dr. A. E. Coates, O.B.E.; Dr. N.-H. Rose, M.B.E.; Dr. S. E. L. Stening, D.S.C.

Rear Admiral W. J. Carr, R.A.N.

The General Secretary reported that a letter of congratulation had been sent by the President to Rear Admiral W. J. Carr on his promotion at the time of his retirement from the position of Director of Naval Medical Services.

The Death of Dr. Frank McCallum.

Reference was made to the death of Dr. Frank McCallum, Director-General of Health of the Commonwealth Department of Health. It was resolved that the Federal Council should place on record its appreciation of the distinguished services rendered by Dr. McCallum to the medical profession and the people of Australia.

The Australasian Medical Publishing Company, Limited.

The General Secretary reported that the Australasian Medical Publishing Company, Limited, had published a list of members of the British Medical Association in Australia. He also reported that the company had resolved to continue to allow a rebate to the Branches of 10s. *per annum* in respect of every member who had totally relinquished civil practice at December 31, 1946, for continuous full-time service with His Majesty's Forces. It was resolved that the company should be thanked for its action.

Publicity.

Dr. W. F. Simmons, Dr. A. J. Collins, Dr. H. C. Colville and Dr. H. R. R. Grieve were appointed members of the Publicity Committee.

The General Secretary reported that the Parent Body in England attached such importance to publicity that it had some years previously appointed a full-time Public Relations Officer. It was, he thought, worthy of note that this officer was of the opinion that no publicity campaign would succeed unless it had the solid backing of the profession. The best publicity officers in matters relating to medicine were medical practitioners themselves. It was also noted that the President had received from the National Physicians Committee for the Extension of Medical Services in the United States of America a publicity pamphlet written in opposition to the nationalization of medicine.

The Organization of the Medical Profession.

The Constitution of the Council and Autonomy of the Branches in Australia.

At the last meeting of the Federal Council Dr. A. E. Lee gave notice that he would move as follows:

1. That steps be taken to modify the composition of the Federal Council so as to secure a representation of the Branches more proportional to their numerical strength.

It is recommended that the primary modification of the Council should consist of: New South Wales, four (4) representatives; Victoria, three (3) representatives; South Australia, two (2) representatives; Western Australia, two (2) representatives; Tasmania, one (1) representative; and that such representation shall be subject to review every five years.

2. That negotiations be resumed with the Council of the British Medical Association to secure autonomy of the profession in Australia by vesting in the Federal Council the control over the Australian profession now exercised by the Central Council; and that the Branches in Australia should be requested to delegate to the Federal Council what-

ever additional powers are necessary to enable it to exercise a governing function over the profession in Australia.

The General Secretary reported that he had submitted Dr. Lee's notice of motion to the Federal Council's legal advisers. They had expressed the opinion that before any amendments to the Articles of Association were effected, it would be necessary to obtain the approval of the Governor in Council. The General Secretary said that he had referred the motion to the Branches and had received replies. The South Australian Branch supported the views of the Queensland Branch, and thought it was important that full power should be given to the Federal Council in regard to any matter affecting Australia as a whole. The Tasmanian Branch reaffirmed its decision that no Branch should have less than two representatives on the Council. The Victorian Branch did not support the Queensland view; it was particularly opposed to anything that might be considered as a severing of the link between Australia and Britain. The New South Wales Branch approved of the notice of motion, but thought that Tasmania should have two representatives. The Western Australian Branch also approved of the motion, but thought that Tasmania should have two representatives. The General Secretary also referred to the discussions which had taken place between representatives of the Federal Council and the Council of the Parent Body in 1938, and also to discussions he had recently had in England with officers of the association. He pointed out that the recent change that had taken place in South Africa, when the South African Medical Association severed its connexion with the British Medical Association and became an affiliated body, was due largely to the political changes that were taking place in the Union. In regard to Dr. Lee's notice of motion, he pointed out that all the States were in favour of its adoption except Victoria. Any proposal to alter the Articles of Association would have to receive the approval of the Parent Body.

Dr. A. E. Lee spoke to his motion. He referred to an article by himself that had been published in *THE MEDICAL JOURNAL OF AUSTRALIA* of September 21, 1946, at page 410, and he emphasized the view that the Federal Council had been created only as a temporary expedient. He pointed out that his proposal that New South Wales should have four representatives, Victoria three, South Australia, Western Australia and Queensland two each, and Tasmania one, was not proportional. At the same time, it did reflect to some extent differences in membership. He proposed to move his motion in two parts. Dr. Victor Hurley, in discussing the first part of Dr. Lee's motion, said that the Victorian Branch had debated the matter, but that this had been before the referendum was held. At that time those who held that no change should be made had admitted that if the Federal Government did secure the powers that it sought in the referendum, the position in regard to the Federal Council representation would have to be reconsidered. With the passage of the referendum, power in the medical field had passed into the hands of the Commonwealth Government. As long as matters medical were State controlled, there was no need to change. As far as he personally was concerned, Dr. Hurley had no doubt that there would have to be an Australian association with powers of its own. In discussing the subject further, Dr. Hurley remarked that under the present Commonwealth financial arrangements the States would have only the moneys which the Federal Government allowed them. His conclusion was that with the altered position powers for the Federal Council were necessary, and also altered representation. Dr. C. Craig moved an amendment, which altered the representation of the Tasmanian Branch to two members. He insisted that with only one representative on the Federal Council a Branch would be at a great disadvantage. It took some time for a Branch representative to become accustomed to the Council's work, and a Branch which was served by only one new representative would be in a very unfair position. Dr. H. R. R. Grieve seconded the amendment. He agreed with Dr. Hurley in what he had said about change having taken place, and said that the only thing to be decided was how many representatives Tasmania should have. He pointed out that constitutions were expedients to give expression to bodies of opinion on democratic principles. In changes such as those envisaged by Dr. Lee there should be some corrective for geography. There were peculiar geographies for the federal systems at large. It was necessary for the medical profession to have an instrument that would give an expression of the opinion of all its parts. Tasmania was a compact Branch and was entitled to something more than unity. It was hard to regard Tasmania as different from the West. He thought that the amendment was correct because of geographical considerations. Dr.

F. W. Carter agreed with the amendment that Tasmania should have two representatives. There could be no such thing in the Federal Council as exact proportional representation. Proportional representation was admittedly democratic, but other factors had to be considered. The Federal Council was not swayed entirely by State considerations. He therefore viewed with some regret the suggestion that proportional representation might be introduced into the Federal Council. Dr. Carter discussed the representation of the States in the Senate of the Commonwealth Parliament, and pointed out that in proportion to other States Tasmania had a larger representation than any of them. Any reorganization should be based on the financial set-up. The smaller States should not necessarily be expected to pay their way, because they had to deal with expenses that were outside the domestic sphere. The President said that he was in favour of two representatives for Tasmania. Dr. N. M. Cuthbert supported Dr. Carter's views. He thought that the time was coming when reorganization would demand that each State have a full-time secretary. The amendment was put to the meeting and carried, and was then carried as the substantive motion.

Dr. A. E. Lee then moved the second half of his notice of motion. He pointed out that this part of his motion really comprised two aspects. On the one hand the Federal Council needed powers which would be conferred on it by the Representative Body of the Association in England, and on the other powers needed to be conferred on the Council by the Australian Branches, and in regard to the latter some legal problems would probably arise. Dr. H. W. Horn seconded the motion. Dr. Victor Hurley suggested that the relationship of the Branches with the Federal Council should be discussed first and powers to be granted by the Central Body secondly. Dr. H. R. R. Grieve said that the Federal Council should be able to tell the Parent Body exactly what powers it needed in order to become really effective. Whether the Federal Council should agree with some alteration of the outward form of its constitution should be considered at a later meeting. As a digression, he said that if it was proposed that there should be any complete divorce from the Parent Body, he would oppose it. There could be no more unfortunate time for any such suggestion than the present. There was more need in the world today than ever before for the preservation of the influence of the whole British people. Returning to the consideration of what should be done to consolidate the powers of the Federal Council because of what lay ahead, Dr. Grieve referred to the question of matters considered by the Branches in turn and then referred to the Federal Council. The present machinery of the Council required that once the Council had dealt with the Branch views, its decisions had to be referred once more to the Branches. This, in his opinion, was mere reduplication. He held that the Federal Council should have the power of laying down a policy once it had heard the views of the Branches. Dr. Grieve said that in order to make this possible, he would propose the following amendment to Dr. Lee's motion:

That, in view of the urgency of the matters before the association, the Branch Councils be asked to agree to the principle that, in respect of questions on which the Branch Councils have made decisions and reported such decisions to the Federal Council, the Federal Council's decisions, made after consideration of such reports, shall become the policy of all the Branches and that the Branch Councils should confer on the Federal Council the constitutional power to state those decisions to all interested bodies as the association's policy; provided that, where important facts in relation to any such question/questions have come to light subsequent to their consideration by the Branch Councils, such facts should be referred to the Branch Councils for further consideration before any binding decision on the question concerned is come to by the Federal Council.

It would, he thought, be impossible to alter the constitution of the Federal Council in such a way as to provide complete machinery to give effect to the views of all the members of the Branches. For example, if a vital matter, such as the institution of a medical service, was under discussion, a majority of the members in one Branch might be opposed to such an idea. He could conceive of no constitution in which the effect of such a position could be avoided, for it would always be possible for some members to be denied the fulfilment of their wishes. It was for this reason that he had added the proviso. The proviso which he had added would reinforce the democratic foundation of the constitution. He held that it was a safe general principle that any alterations in a constitution should be made slowly, and

that even when changes were made they should not go too far. Dr. C. Craig seconded Dr. Grieve's amendment. He said that the amendment eliminated the last reference to the Branches, which at the present time was a great weakness. It was, of course, impossible for the Federal Council to rule without previous consultation with the Branches. Dr. A. E. Lee, speaking to the amendment, asked whether the proposal involved a legal transfer of powers. No permanent powers from Branch Councils had been asked for, and it was important to consider the legal binding of a Branch which held a minority view. Dr. Grieve said that he thought that any transfer of powers should be on a legal basis. Dr. Lee said that it was necessary to decide first of all what the matters were on which powers were required, and secondly, of what the power was to consist. The only power of which he could conceive was disciplinary power. The President remarked that Dr. Grieve's amendment put on the Branch Councils the onus of reflecting the views of their members. The Federal Council had every right to act on Branch views presented to it, and he thought that it should have the power to do so. The General Secretary referred to the legal powers of the Federal Council. He said that as at present constituted, the Federal Council had powers over none but its twelve members. The State Branches were six separate entities. If the Federal Council was the executive body of the Branches, the position would be analogous to that existing in South Africa. Dr. F. L. Davies thought that the adoption of Dr. Grieve's amendment would be an advance. In reference to important minorities in a Branch who were in opposition to Federal Council views, Dr. H. R. R. Grieve said that the Federal Council would give very careful consideration to the laying down of a strong policy on any matter. Dr. Victor Hurley said that to allow a minority to rule was to encourage direct action. He thought that Dr. Grieve's idea was only the first step in what should be done. The General Secretary agreed with Dr. Hurley's view. The President then put the amendment, which was carried and then adopted as the substantive motion.

Dr. A. E. Lee then moved the first part of his notice of motion dealing with the acquisition of powers by the Federal Council. The motion was seconded by Dr. Victor Hurley. Dr. H. R. R. Grieve could not see how autonomy could be increased without separation from the Parent Body. With this Dr. F. L. Davies agreed. The General Secretary pointed out that the Federal Council was not hampered at present in any of its actions, although an alteration of Articles of Association had to receive formal approval from the Parent Body. The President said that it was not intended to ask for complete autonomy. Dr. Lee, with the permission of the meeting, withdrew his motion and moved that legal opinion should be obtained regarding the necessary structure which should be built up in order to obtain for the Federal Council the powers envisaged in the preceding resolution. This motion was carried. After further discussion it was resolved that if all the Branches were willing to accept the proposed altered constitution of the Federal Council, the General Secretary should be authorized to take what legal steps were necessary to amend the Articles of Association.

Finance and the Western Australian Branch.

At the previous meeting of the Federal Council a letter was received from the Western Australian Branch in regard to the financial condition in which it found itself. It was pointed out that the Branch subscription was nine guineas *per annum*, and that the Branch was at an awkward stage in its evolution. It had passed beyond the stage at which it could be conducted by voluntary officers, and as matters stood the activities of the Branch would have to be cut down or the subscription would have to be raised, or some financial assistance would have to be given to the Branch. It was resolved at the last meeting that the General Secretary on his next visit to Western Australia should discuss the matter with the Branch Council. The General Secretary now reported that he had had an opportunity of discussing the situation with the Western Australian Branch. He had concluded that the difficulties in Western Australia were due primarily to the intense interest taken by the Branch in the affairs of the association, and in the attempts of the Branch Council to provide facilities to its members. The Branch covered an enormous area, and the membership was not large. In fact, the number of medical practitioners in the State was not large. The only answer that he could see was that the States with large membership lists should assist those whose membership could not be large. This was necessary for organization purposes, in order to help them to carry on for the time being. The deficit in Western Australia for the current year would be something in the neighbourhood of £207. Dr. W. F. Simmons, remarking

that the strength of any chain was that of its weakest link, said that some means should be found to help large States with small medical populations to be built up and organized to function in the same fashion as the States which had a large membership. The time had certainly come, Dr. Simmons insisted, when all the links in the chain needed to be strong. He thought it might be possible to earmark a proportion of the money raised by the *per capita* payment for organization purposes and to use it for helping outlying States. New South Wales and Victoria should realize their duty to the other States. If the Branches had an "All Australia" outlook, it would be realized that organization was necessary even if a higher *per capita* payment had to be made. Dr. F. W. Carter said that the problem did not affect his own State only, and Western Australia did not wish to appear as a mendicant State approaching the more fortunate States. However, the Western Australian Branch had not been over-generous to themselves in the matter of spending. The whole question had Association-wide implications, and he thought that the Association had sufficiently imbibed the federal spirit to think along federal lines. It would be a retrograde step for any Branch to depart from its standard of living. In regard to the use of federal funds for State purposes, Dr. Carter pointed out that the Federal Council, as it was, spent something like £400 per year to bring Western Australian representatives to its meetings, and this was more than twice as much as Western Australia paid in *per capita* payments. This meant that some States were already contributing towards the expenses of the more distant States. Numbers did have a bearing on the question, because clearly the overhead costs of small Branches would be proportionately higher than those of the larger Branches. Certain amenities in the corporate life of Branches had to be observed. The difference between output and intake allowed a balance to be made, and when a Branch was on the bread-line it could not afford the amenities for its members which it thought they should have. There was no doubt that the work in the Branches was increasing. In Western Australia they had convened a convocation, and members of the Council went to country areas to keep members alive and interested in Association affairs. The feeling among members on Association matters was 50% better than it used to be. In order to bring this about, the Western Australian Branch had had to spend money, and they were now on the bread-line. Men were coming back from active service, and it was quite likely that before long, with the resulting increased contributions, it would be possible to balance the budget. The Branch did need a professional medical secretary. Dr. Carter again said that he was sorry to refer so much to his own Branch, but he thought that it with others carried too big a share of responsibility in relation to its numbers, and he for one would like to see some approval given of the work that had been undertaken to increase Branch enthusiasm. He did not agree that an organization fund should be used only for the benefit of those who had subscribed to it. He held that relief given could come from the capitation fee and should be for the relief of those who had suffered by furthering nation-wide activities. Dr. N. M. Cuthbert pointed out that prior to the present meeting the centre of gravity had been with the States. He thought that at the present time it was with the Federal Council. Dr. C. Craig agreed with what had been said, and he pointed out that small States were carrying on under disabilities of varying kinds. The President agreed that Dr. Simmons and Dr. Cuthbert had made out a good case for the giving of help to the Western Australian Branch. The Federal Council had the power to do what was suggested, and he quoted the article in its constitution which allowed this to be done. He referred incidentally to the running of a Branch library, which was an expense, and thought that when a medical school was founded in Western Australia, that State should follow the South Australian method of library practice. In Adelaide all the medical books were transferred to the University of Adelaide, and the University Library housed not only its own volumes, but also medical books from the Public Library and journals and books from the South Australian Branch. The University Library also acted as a circulating library. In order to help this arrangement, the city members of the Branch paid a sum of 10s. a year to the library fund. Dr. Victor Hurley said that he accepted the principle that help should be given to the Branches with smaller membership, but thought that any help should be for organization purposes only. He therefore moved:

That the Federal Council be prepared to grant financial assistance for organization purposes to the smaller Branches when these Branches are required to undertake such work in matters affecting the interests of the profession as a whole.

The motion was seconded by Dr. H. R. R. Grieve and carried.

Report of the General Secretary on His Visit to England.

The Federal Council had before it a long report by the General Secretary on the observations made by him during his visit to England to attend the Special Meeting of the Representative Body in May, 1946. The report dealt *inter alia* with the British Government's proposals for a national health service and the views of the medical profession in regard to them, with organization of the profession, with post-graduate education in England, and also with provident medical schemes. It was pointed out that the document was so extensive that members of the Federal Council had had no opportunity to study it. It was therefore resolved that consideration should be deferred.

Dr. W. F. Simmons.

At this stage the President referred from the chair to the value of the services performed by Dr. W. F. Simmons as Acting General Secretary of the Federal Council while the General Secretary, Dr. J. G. Hunter, was absent in England on the business of the Council. The President moved and Dr. H. R. R. Grieve seconded a motion expressing the appreciation and gratitude of the Council to Dr. Simmons. The motion was carried with enthusiasm.

Medical Planning.

The Commonwealth Government's Plans for Complete Medical Service.

The General Secretary referred to an invitation which had been received in May, 1946, from Senator J. M. Fraser, who at the time was Commonwealth Minister for Health. The invitation had been sent to the President. The Minister's letter was as follows:

Commonwealth of Australia.
Minister for Health and Minister for
Social Services,
Commonwealth Offices,
Melbourne, C2,
13th May, 1946.

Dear Sir Henry,

At a conference with Ministers for Health of each State, held at Canberra on 6th May, I put forward the Commonwealth Government's proposals for a complete medical service for the people of Australia.

The ultimate objective is that there shall be a complete medical service, comprising medical practitioners, specialists, pathologists, radiologists, and other ancillary services, available to the people free of charge.

The Commonwealth proposes that there shall be established, at suitable centres throughout Australia, medical centres where the people of Australia may obtain both pathological, radiological and other specialist attention. Some of these centres will be built by the Commonwealth and others will be in association with hospitals—some being established in country towns and others in the metropolitan area.

It is proposed that medical officers shall attend at these centres either on a full-time basis, or, in some cases, on a part-time sessional basis.

It will be necessary to establish training schools for pathologists, biochemists, radiologists and technicians, and arrange for the training of other specialists.

There are many details to be settled, and for this purpose the conference agreed to appoint two committees to report at the next conference of Ministers for Health upon the practical aspects of a National Medical Service.

The first committee, consisting of departmental officers, will consider the practical aspects of the scheme and will try to establish a basis upon matters of policy, which will be submitted to the next conference of Ministers for Health.

The second committee will be one to determine—

- (1) the location of centres in the country and in the metropolitan area;
- (2) the type of centre required at each location;
- (3) the types of specialists required at each centre;
- (4) the localities in which flying doctor services or other mobile units are desirable;
- (5) the nature and type of existing and desirable pathological, radiological and specialist services in each town; and
- (6) the localities where one-man medical practices should be established.

This committee will commence its inquiries at once. Much of the information required will be available

from departmental sources, but there will be also needed an extensive survey of some areas.

The Government has laid down two major items of policy upon which the service will be based—

- (1) Every person in Australia shall be entitled to medical attention without regard to his economic status and without any direct charge for the service.
- (2) This medical service shall include the full range of medical attention, including all modern diagnosis and specialist services.

I am anxious that no source of information should be overlooked when we are determining the location and types of the various centres, etc. It is realized that the medical profession can contribute a great deal towards a solution of these problems, and it would be appreciated if your Council would nominate in each State a representative of the British Medical Association to be a member of this committee. The committee will meet at the capital city of each State at times to be decided by the chairman.

Yours sincerely,

J. M. FRASER.

Sir Henry Newland, Kt., C.B.E., D.S.O., F.R.C.S.,
President, Federal Council of the British Medical
Association,
163 North Terrace,
Adelaide, S.A.

To the Minister's invitation the President replied on June 13, 1946, in the following terms:

Dear Mr. Minister,

Upon the receipt of your letter dated 13th May, 1946, I at once sought the views of my colleagues on the Federal Council, and also those of the Councils of the State Branches of the British Medical Association concerning your invitation to the Federal Council to nominate in each State a representative of the British Medical Association to be a member of the second committee. The duties of the committee were defined by you.

I am now in a position to reply that an important feature of the policy of the Federal Council is a complete medical service, with the inclusion of a full range of medical attention and all modern diagnostic and specialist services. (See pages 11-12, Interim Report of the Medical Planning Committee of the Commonwealth Parliamentary Joint Committee on Social Security.)

As, however, the first departmental committee, which is to consider the practical aspects of the scheme, has not yet established a basis upon matters of policy and reported thereon to a conference of Ministers for Health, the Federal Council is of the opinion that, at the present stage, it would be premature for it to nominate in each State a representative of the British Medical Association to be a member of the second committee.

The Federal Council desires me to assure you that it appreciates your invitation and regrets the delay in replying to it.

Yours sincerely,

H. S. NEWLAND,

President.

The General Secretary reported that in June, 1946, the President had received a letter from Senator N. E. McKenna on his appointment as Minister for Health. In this letter the Minister said that he noted that the Federal Council was not prepared to nominate in each State a representative of the association to be a member of the Second Committee. He also gathered from the letter that the Federal Council would not consider the making of any such nomination until after the First Committee had reported to a conference of Ministers for Health. He wished to know whether his understanding of the position was correct. To this the President had replied that the Minister's understanding of the position was correct. After receipt of a further letter from the Minister in July, 1946, the President had written to the Minister a letter in which he stated that, should the present Government be in office at the latter part of the year, and should Senator McKenna continue to hold his present ministerial position, the President trusted that he, the Minister, would invite the Federal Council to confer with him on the plans which he had in view for a national medical scheme. The General Secretary stated that committees had been appointed and were at work. The present position was discussed at some length, and after the President had read the policy of the Federal Council (see THE MEDICAL JOURNAL OF AUSTRALIA, April 24, 1943, page 373), it was resolved on the motion of Dr. A. E. Lee,

seconded by Dr. H. R. R. Grieve, that the Council reaffirm its existing policy in regard to general medical services. The Federal Council also discussed the possible appointment of advisory medical officers to the Government, and it was resolved that members should be advised not to accept any such appointments in matters relating to the provision of medical services till further discussions between representatives of the Federal Council and members of the Government had taken place.

A letter was received from the Queensland Branch, enclosing the copy of a letter which it had received from Professor John Bostock on the psychological aspect of a general medical service. The letter contained recommendations from the Australasian Association of Psychiatrists. It was resolved that the Australasian Association of Psychiatrists should be thanked for its letter and should be informed that the psychological aspect of the problem was receiving consideration along with all the other aspects involved.

The New Zealand Medical and Hospital Benefits Scheme.

The General Secretary reported that he had received from the South Australian Branch a copy of a recent report on the New Zealand Medical and Hospital Benefits Scheme. It was stated that the cost of the New Zealand service was still going up. The plan was now costing approximately £6 s. a head per annum. The total costs were now over £10,000,000 per annum, and hospital services alone cost over £5,000,000.

A Brochure for Public Circulation.

Further reference was made to the issuing to the public of a brochure on the subject of a general medical service. It was resolved that the matter should be referred to the Publicity Committee.

Hospital Services.

At the previous meeting of the Federal Council a lengthy discussion on hospital services took place (see THE MEDICAL JOURNAL OF AUSTRALIA, April 20, 1946, page 563). During that discussion, in which the Federal Council declared its view that it was wrong for members of the Branches to treat in public wards of hospitals patients who could afford to pay for intermediate or private treatment, it was resolved that the decision was not to be operative in each State in a uniform fashion, but that each State should adopt its own plan of action. The General Secretary reported shortly the developments which had taken place in the States since the previous meeting. In South Australia the honorary medical officers of hospitals had decided to carry on as usual. In Victoria no alteration in practice had taken place. A questionnaire had been sent to members of the Victorian Branch on the matter, and it appeared from the replies that the members were opposed to the abolition of the honorary system. The Queensland Branch reported that in that State no change had taken place; the *Hospitals Benefits Act* had not been fully implemented. The Western Australian Branch wrote that it would keep the Federal Council advised of any change. The New South Wales Branch forwarded a resolution adopted by its members which had a threefold bearing. The resolution declared (a) that the classification of patients into public, intermediate and private categories should be carried out, (b) that no payment should be accepted for honorary services, (c) that practitioners should refuse to treat in an honorary capacity patients who could afford to pay, except in conditions of extreme emergency. During the discussion Dr. Victor Hurley pointed out that in certain circumstances charges could be made by medical officers attending hospitals. Dr. H. R. R. Grieve pointed out that in New South Wales it was competent for a hospital board to declare certain beds to be public or intermediate beds, and that most hospitals were willing to do this. He thought that hospital boards should be asked to make such declarations, and he also suggested that when a patient was to be admitted to hospital, he should be asked to sign a letter to the hospital secretary asking for private or intermediate accommodation as he desired. Dr. Grieve asserted the moral right of a medical officer to refuse to treat free of charge any patient who could afford to pay.

The General Secretary read a letter from the Western Australian Branch, in which it asked the Federal Council to consider the whole question of service in public hospitals, more especially as it concerned the future of the general practitioner. He also read a letter in which the Western Australian Branch set out its own views on the matter. In this letter the following points were emphasized: (i) that all hospitals should be essentially community hospitals, in which there would be a proportion of public beds; (ii) that the Perth Hospital, the Children's Hospital, Perth, and the King Edward Memorial Hospital, and all government con-

trolled and subsidized hospitals in the State, should be gazetted as community hospitals; (iii) that the acceptance of appointments on visiting staffs by members of the profession should be contingent on the declaration of these hospitals as community hospitals; (iv) that the acceptance of future appointments should be contingent upon adequate representation of the medical profession on the boards of the institutions; (v) that if representation on boards was not obtainable, a medical committee should be set up for each institution, that the medical superintendent should be chairman of this committee, and that it should be made responsible for the planning of medical services and clinics, the future developments of hospital accommodation, the instruction of resident medical officers and nurses, the provision and maintenance of medical equipment and the control of the medical staff. The General Secretary said that he had sent the Western Australian Branch letter to the other Branches and had received replies. The Tasmanian Branch supported the Western Australian views, as also did the South Australian Branch. The New South Wales Branch gave a general approval and supported the views where they were applicable to New South Wales conditions. The Queensland Branch replied setting out the state of affairs existing in that State. It suggested that the Western Australian Branch might be prepared to consider the establishment of part-time paid appointments. The Victorian Branch left the matter in the hands of its delegates.

Dr. A. E. Lee said that in Queensland members of the profession were carrying out the specialized part of a part-time paid medical service. The paid staff attended the Brisbane General Hospital with its 2,200 beds. This was an important service to the community. Dr. Lee thought that the question urgently needed consideration. During the war no particular terms and conditions of service had been laid down, though the appointments were made on a yearly basis. It was proposed that in February, 1947, appointments would be made for a longer period. Applications would probably be invited for a period of five years. During the tenure of an appointment it was difficult to obtain a variation of conditions. Medical practitioners could not and would not strike, but they could refuse to apply for positions unless the terms were acceptable. Several aspects had to be considered. First of all, in regard to the way in which appointments were made, if the method was wrong the whole service would suffer. In Queensland the Hospitals Board was a board of laymen, and the visiting staff were regarded as casual labour. The only person who could give advice was the medical superintendent. There was an exception in the case of a teaching hospital, where applications could be placed before the Director-General of Health and the Conjoint Board. The Conjoint Board consisted of four persons. Of these four persons, one was an electrician, another was a clerk, a third was a professor of English in the University of Queensland, and the fourth was the Dean of the Faculty of Medicine, who was not at present a practising doctor. The second point which Dr. Lee wished to make was that professional control should be in the hands of a medical committee elected by the staff. Thirdly, he held that the conditions of work and remuneration should be adequate. The payment that was received was below that paid by the Repatriation Department and also less than sessional pay by the army.

It should be noted that the Federal Council had before it a statement on the terms of service of the part-time visiting staff of the Brisbane General Hospital. The statement is as follows:

1. Subject to the administrative supervision of the General Medical Superintendent, visiting medical officers have professional charge of patients admitted under their care.
2. Appointments are made for five years in the case of seniors—three years for juniors—and yearly for assistants.
3. Payment is on a sessional basis, at the rate of £3 10s. per three-hour sessions for seniors—£2 10s. for juniors—and £2 for assistants. The maximum number of sessions worked weekly is four. No payment is made for overtime or for extra sessions. Officially, no allowance is made for sick leave or for vacations, though actually, at his discretion, the Medical Superintendent may direct payment during sickness up to two weeks annually, and also payment for sessions not attended because there was no work to do (as in operating sessions).
4. All the public hospitals in the Brisbane area (except denominational hospitals) are controlled by the Brisbane

and South Coast Hospitals Board, consisting exclusively of laymen, eight nominated by the Government, and one by the local authorities. Its only medical adviser is the General Medical Superintendent, and visiting staffs have no access to the Board, except through the Superintendent, who exercises his discretion as to transmitting their communications.

5. Medical staff appointments are made by the Board, on the advice of the Medical Superintendent. Applications for part-time appointments are also sent to the Director-General of Health for his comments. In the case of teaching hospitals, the Director-General is advised by a committee consisting of two members nominated by the Senate of the University, and two members representing the Hospitals Board. At present this committee consists of the Dean of the Faculty of Medicine and the Professor of English, on the one part, and a clerical officer of the Department of Health and a member of the Electrical Trades Union, on the other. The Board is not bound to accept the advice of the Director-General or the Medical Superintendent.

6. Members of visiting staffs under the control of the Board are not allowed to accept any other public hospital appointments.

7. All facilities of the Brisbane Hospital are free, both in-patient and out-patient, and there is no imposition of a means test.

Dr. N. M. Cuthbert observed that the number of members on a staff was reduced when the staff was paid. When this happened it was a simple matter for boards to switch over to a fully paid permanent staff. He was firmly of the opinion that the Queensland hospital should be on the community basis, and that the medical staff should have representation on the boards. One point which was frequently forgotten was that adequate staffing by visiting medical officers was necessary in order that younger men should be trained. In Western Australia lay control was also creeping in. This was shown by the letterheads, which bore the words: "All communications to be addressed to the Business Manager." Dr. Victor Hurley said that the system was different in the different States. Victoria still had control by hospital boards of management, though they might end by being controlled in the way that obtained in Queensland and other States. There was no doubt in his mind that professional matters should be dealt with quite separately from matters of pure business. He also agreed that the system of appointment to hospital boards should have nothing to do with matters of management. With regard to representation of medical staff on a board, there was not a great deal in it. If an acute problem arose, the presence of two men on a board did not make a great deal of difference. It was then much better that matters should be referred to the staff as a whole. After further discussion it was resolved on the motion of Dr. Victor Hurley:

That the Federal Council is of the opinion:

1. That professional appointments to large public hospitals and in particular to teaching hospitals, shall be made on the advice of an advisory board or committee on which there is adequate medical representation.
2. That there should be adequate medical representation on the Boards of Management of these hospitals.
3. That professional matters and, in particular, matters affecting the work of members of the medical staff in the hospital be referred to the staff for their advice.
4. That the terms of remuneration of the visiting medical staff of the Brisbane General Hospital are quite inadequate.

The General Secretary referred to the remuneration of visiting medical officers of voluntary hospitals, and said that he had written to the Parent Body to inquire about conditions prevailing in England. He pointed out that the information for which he had asked would be found in the *British Medical Journal* of April 20, 1946, on page 94 of the supplement.

At the previous meeting of the Federal Council attention was drawn to the acute shortage of hospital beds, not only for public hospital patients, but more particularly for private and intermediate patients. It was resolved on that occasion that the matter should be brought to the notice of the Prime Minister. It was to be pointed out to him that the position had largely arisen because of (a) the impossibility of obtaining sufficient staff to run the hospitals and (b) the increased cost of running, which had already forced many

of these hospitals to close. The General Secretary read a reply which he had received from the Prime Minister, in which it was stated that the Commonwealth Prices Commissioner, to whom the Federal Council representations had been referred, had advised that tentative approvals had been given in respect of applications for a higher scale of fees lodged by various private hospitals. It was pointed out that these approvals would permit of increased fees only to the extent necessary to recoup increased costs incurred as a result of increased rates for nursing and domestic staffs. Confirmation of the tentative approval would be given with the concurrence of the Department of Health only after each application had been closely investigated. It was pointed out in discussion on this letter that commodities had gone up enormously in price and that many hospitals were finding it impossible to pay their way on this account. After further discussion the Federal Council adopted a resolution in which it expressed the view that in respect of the increased cost incurred in running private hospitals, the factor of the increase in cost of equipment and foodstuffs should be taken into consideration when the fees that should be charged in such hospitals were determined.

In regard to the shortage of beds for maternity accommodation, the General Secretary read a letter that he had received from the South Australian Branch. This letter conveyed a resolution of the South Australian Branch Council to the effect that the Federal Council should be asked to make representation to the Nurses Registration Boards of all States, pointing out the advisability of withholding midwifery nursing certificates from all midwifery nursing graduates until they produced evidence of having completed three months' midwifery hospital service subsequent to the completion of their undergraduate midwifery training time and examination pass. It was thought that in a matter of this kind coordination of action by all the States would be necessary. The General Secretary reported that he had referred this matter to the Branches. The Victorian Branch had left the matter in the hands of its delegates. The Queensland Branch had not approved of the proposal. The New South Wales Branch had decided that the proposal was impracticable, and the Tasmanian Branch thought that no useful purpose would be achieved by its adoption. Dr. R. J. Verco said that he thought it was strange that the Queensland Branch should oppose the suggestion, in view of the fact that medical students had to serve in hospital for twelve months after passing their university examinations before they could be registered. During the war the rule that nurses would be required to serve three months in a maternity hospital before they received their certificates had operated. The rule had now been suspended and the number of nurses had promptly dropped. All maternity hospitals were understaffed. All nurses wanted to be doubly certificated. In bygone days midwifery nurses had held a nursing certificate. Nurses who sought double certificates were using all the clinical material. They wanted to hold these double certificates in order to obtain jobs as matrons of hospitals. In these circumstances they were no use whatever as maternity nurses, and they had no opportunity to train others in midwifery. If the recommendation that had been suggested was adopted, it would have to be universally introduced, otherwise all the nurses would go to States in which the requirement did not operate. Dr. F. W. Carter said that Western Australia had turned down the proposal because the suggestion was a matter of expediency. Dr. F. L. Davies thought that the proposal if adopted would amount to coercion. No objection could be raised to the suggestion if the requirement was made clear to nurses before they started their training. Dr. H. W. Horn said that the matter was one of freedom. They were asked to support a threat to the freedom of a nurse, and the proposal did not attack the cause of the shortage. Dr. H. R. R. Grieve said that nurses had a perfect right to choose their career. If any alteration was brought about, an amending act would be necessary. The correspondence was received.

At the instance of Dr. F. W. Carter the Federal Council discussed the question of community hospitals. Dr. Carter pointed out that during the war honorary staffs had become depleted for two reasons. The first was the enlistment of doctors who were already on the staff, and the second was the dearth of young men who normally would have become members of a staff had it not been for their enlistment with the forces. Since the return of ex-service personnel and their availability for nomination, conditions had arisen which precluded their appointment except in the case of former members of honorary staffs who had resumed their former positions. The abolition of the means test with the

assumption by the Government of responsibility for the payment of the profession for services hitherto rendered in an honorary capacity raised the important question of the relationship of the system to the profession generally. The Commonwealth Government had, rightly or wrongly, undertaken to provide medical services free of cost to all members of the community who entered public hospitals and occupied public beds. To do this it had to buy the services of the only body competent to run them—the medical profession. The medical acts of the several States had laid down standards of efficiency required of medical graduates before registration entitling them to practise could be effected. Any scheme which directly or indirectly would deprive any or all of them of the privilege of such registration could not be countenanced by the British Medical Association. This in effect would take place when, with the abolition of the means test and the honorary system, a select group of practitioners would have the exclusive right to attend the Perth Hospital and receive fees for their services to the exclusion of all other practitioners. Patients of the excluded practitioners, exercising their right of admission to the institution, would be forced to undergo treatment at the hands of the select group, and would be deprived of their right to choose a medical attendant. It might be claimed, Dr. Carter said, that the guarantee of 6s. per day towards the hospital expenses of patients in private hospitals adequately protected the private practitioner. There were two reasons why this was not true, the insufficiency of bed accommodation to satisfy the demand, and the responsibility of the patient for medical costs. In regard to the former, the steady decrease in private hospital accommodation would have the effect of driving patients into public hospitals and away from the doctor of their choice. The law victimized the thrifty, who were able and willing to pay for the more comfortable accommodation of the private hospital, but perhaps were unable to pay for medical services. In either case the effect would be the same. Dr. Carter pointed out that with the completion and opening of the modern Perth Hospital, many who now refused to enter it would then elect to do so. When that state of affairs was reached, the "outsider" man would have become merely a reference clerk, unless provision had been made for him to continue to attend his patients after their admission to hospital. In view of this, and for other reasons, it was essential that there should be community beds in all public hospitals, together with separate operating theatre accommodation which would be available to all practitioners. In hospitals where provision had been made for public patients only, an adequate number of existing wards should be declared community wards, pending the erection of a separate community section.

Dr. Carter went on to say that it was recognized that senior positions in public hospitals should be held by specialists of the highest efficiency. Whether they were attached to a university or not, these institutions were teaching schools, and no consideration should be allowed to interfere with or limit that function. What the relationship of clinical teaching would be to any system of sessional or per service payment was a matter which would no doubt receive the closest attention of the profession and of the teaching bodies before completion of the basis on which appointees accepted positions on hospital staffs. However widely the doors were opened to the general body of practitioners, there could be no curtailment of beds or of material to a point which would handicap either post-graduate or undergraduate education. There being no "indigents" or "sick poor", all appointments other than those mentioned should be contingent on acceptance of the policy of "open house" by the Government or other controlling body. In the making of these appointments, preference should be given to men who had served with the forces, provided other considerations were equal. There was no reason to fear that patients requiring specialist treatment would not be referred to the specialist first, as they were at the present time. This raised the question of the necessity for laying down standards of qualification for those who wished to undertake certain procedures, together with the question of statutory power to restrain practitioners not qualified to undertake such work. Dr. Carter then referred to the question of maintenance of private hospital accommodation, and went on to say that theoretically all medical services should be paid for on a per service basis, the rates falling with the standards of the practitioner and the service rendered. He held that with the exception of certain positions, the question of a per service basis for all payments in respect of the present hospital impasse should be closely studied before a sessional basis was adopted. Dr. H. R. R. Grieve expressed his agreement with the principles enunciated by Dr. Carter, and Dr. N. M. Cuthbert said that the Federal Council should press for the adoption of com-

munity principles. In this matter the Federal Council adopted two resolutions, as follows:

That the Federal Council is of the opinion that all public hospitals should be essentially community hospitals where provision is made for private and intermediate beds as well as for public beds.

That the British Medical Association, through its Branches in Australia, should press for the acceptance of the community principle in hospital administration in order that all doctors may have the right to follow their patients into hospital.

The General Secretary reported that he had received from the Under Secretary of the Department of Public Health, Western Australia, a copy of a report by Dr. L. E. Le Souef, of Perth, on hospital planning, administration and architecture, as observed in Sweden, England, Wales, Canada and the United States of America.

The Pharmaceutical Benefits Act, 1944.

The General Secretary read a letter from the New South Wales Branch, in which the view was expressed that the policy of the Federal Council should be adhered to pending the announcement of altered intentions on the part of the Commonwealth Government. Dr. W. F. Simmons moved and Dr. H. R. R. Grieve seconded a motion in accordance with the views of the New South Wales Branch. Dr. F. L. Davies asked whether such a motion was necessary, in view of the Federal Council's declared policy. The motion was put to the meeting and carried.

The Medical Benefits Fund of New South Wales.

The General Secretary referred to an outline of the scheme of the Medical Benefits Fund of New South Wales, Limited, which had been sent to the Branches and to members of the Federal Council. Dr. H. R. R. Grieve said that the company had been registered and the directors appointed. The company was holding its first meeting while the Federal Council was in session. He pointed out that the directors of the company were virtually the members of the Council of the Branch. He explained the general outline of the scheme, and said that the Metropolitan Hospitals Contribution Fund was acting as agent or collector. Dr. F. W. Carter pointed out that the patient who sought the advice of a doctor not a member of the company was placed at a certain disadvantage as compared with the patient whose medical practitioner did belong to that body. He asked whether this did not penalize the former type of patient, and whether the arrangement did not in fact interfere to a certain extent with a patient's choice of doctor. Dr. F. L. Davies said that he was glad Dr. Carter had brought up that point, because he thought that anything that might be construed as coercive action would be objectionable. Dr. H. R. R. Grieve explained that after all the scheme was a form of insurance, but he gave an undertaking to put the views before the members of the New South Wales Branch Council.

A letter had also been received from the Friendly Societies of Australia, inquiring whether the fund was regarded by the profession as a plan which was likely to supersede lodge contract service. It was explained that this was by no means the intention, and it was suggested that arrangements might be made so that the friendly societies could act as agents for the fund.

Contract Practice.

Contract Practice Committee.

The Contract Practice Committee of the Federal Council was reappointed as follows: New South Wales, Dr. H. R. R. Grieve; Queensland, Dr. L. P. Winterbotham; South Australia, Dr. R. J. Verco; Tasmania, Dr. J. R. Robertson; Victoria, Dr. C. H. Dickson; Western Australia, Dr. H. Leigh Cook; with the President *ex officio*.

The Federal Common Form of Agreement.

The General Secretary said that he had received from the Federal Council of the Friendly Societies of Australia a further set of amendments suggested by that body in connexion with the Federal Common Form of Agreement for friendly society contract medical practice. These amendments covered almost every clause in the agreement. Many of them were concerned only with minor points. They were discussed *seriatim*. Some of the amendments were accepted and some were rejected. In regard to the question of rates, it was resolved that the rate of attendance per member *per annum* should be 36s. in the metropolitan area and 44s. in country areas, that the rate for attendance per single female member *per annum* should be 27s. in the metropolitan area

and 33s. in country areas, that the rate for attendance on juvenile members *per annum* should be 18s. in the metropolitan area and 22s. in country areas. It was resolved that the supply of medicines should be at the rate of 18s. per member *per annum* and that the rates for attendance should be basic rates. It was finally resolved that the Federal Common Form of Agreement as amended should be adopted and forwarded to the Federal Council of the Friendly Societies of Australia with the statement that it represented the final consideration by the Association in the matter.

The General Secretary reported that the Friendly Societies Association of New South Wales had approached the New South Wales Branch with a suggestion that the Common Form of Agreement as finally approved by the Federal Council should be introduced in New South Wales. A deputation from the Friendly Societies Association had met the New South Wales Branch Council and had explained that it was desirable from the friendly society point of view that the agreement should be implemented as soon as possible. After discussion the Federal Council resolved as follows:

That Branch Councils be advised of the desirability that formal notice should be given to the Friendly Society authorities throughout Australia of the intention of the British Medical Association in Australia to terminate any agreements, actual or implied, existing between that Association and the Friendly Societies Councils of the various States and any of the individual Friendly Society lodges.

International Medical Conference.

The General Secretary referred to an invitation which had been received by the Federal Council from the Secretary of the Parent Association for the Federal Council to appoint a delegate to a conference which was to be held in London on the desirability of creating an international medical organization, which would promote closer ties among the different national medical organizations. (See THE MEDICAL JOURNAL OF AUSTRALIA, August 24, 1946, page 277.) He reported that a conference had been held in London on September 25 to 27, 1946, and that Dr. John H. Anderson had been appointed the representative of the Federal Council. Dr. Anderson had forwarded a report, copies of which had been sent to the Branches and to the members of the Federal Council. A report of this conference will be found in the *British Medical Journal* of October 5, 1946. It was resolved that the action of the President in appointing Dr. J. H. Anderson as representative of the Federal Council at the conference should be approved, and that Dr. Anderson should be thanked for his very full and informative report, and that he should be requested to act as representative of the Federal Council on the newly formed World Medical Association.

The General Secretary also reported that some correspondence had taken place between the Chairman of Directors of the Australasian Medical Publishing Company, Limited, and the President of the Federal Council in regard to a proposal that the Editor of THE MEDICAL JOURNAL OF AUSTRALIA might be sent as a representative to the conference. The correspondence was noted.

South African Medical Congress, Medical Association of South Africa.

The General Secretary reported that an invitation had been received from the Medical Association of South Africa, suggesting that members of the Branches might attend the thirteenth annual scientific meeting and the thirty-fourth medical congress of the Medical Association of South Africa, which was to be held in Durban from October 7 to 12, 1946. It had not been possible for any Australian practitioners to accept this invitation, but he said that when he called at Durban on his return journey from England he had conveyed the best wishes of the Australian Branches to the officers of the congress.

The National Health and Medical Research Council.

The General Secretary reported that he had received the final reports of the twentieth session of the National Health and Medical Research Council held at Canberra on November 20 to 22, 1945, and also the final report of the twenty-first session held on May 28 and 29, 1946. These had been forwarded to the members of the Federal Council. He also stated that he had received from Dr. W. F. Simmons, representative of the Federal Council on the National Health and Medical Research Council, an account of the meeting held on May 28 and 29. Copies of Dr. Simmons's report had been sent to the Branches and to the members of the Federal Council.

The Commonwealth Council for National Fitness.

The General Secretary stated that he had received from the Acting Director-General of Health of the Commonwealth a report of the eighth session of the Commonwealth Council for National Fitness, held at Melbourne on October 25 and 26, 1945. The report was received.

Medical Research in Australia.

At its previous meeting the Federal Council discussed medical research in the Commonwealth of Australia and resolved that the Federal Council should write to the Prime Minister, protesting that insufficient funds were being made available to the National Health and Medical Research Council, and pointing out that the council was finding it necessary to curtail its activities at a time when an advancement of its work was an urgent national need. The General Secretary said that he had written to the Prime Minister in April, 1946, in the terms of the Federal Council's resolution, and had urged that special consideration should be given to increasing the grant to the National Health and Medical Research Council for research purposes. A reply dated May 16, 1946, had been received from the Prime Minister. In this letter it was stated that the Commonwealth Government was vitally interested in the question of medical research and was investigating the whole problem. Inquiries were being made into the development of a medical institute of research in connexion with the Canberra University, and a technical subcommittee had been appointed to inquire into details regarding the future allocation of funds for research. It was added that the Commonwealth Government was fully anxious to do its duty in problems of medical research, and would give full consideration to any proposition on the subject that was put before it. The General Secretary also read a letter addressed to Dr. Simmons from the Acting Director-General of Health, who was also Acting Chairman of the National Health and Medical Research Council. In this letter it was pointed out that, following on the visit of Sir Howard Florey to Australia, the Commonwealth Government had appointed a Cabinet Subcommittee to explore the whole question of medical research. This Cabinet Subcommittee had appointed a Technical Advisory Committee on Medical Research, consisting of Sir Alan Newton, Professor F. M. Burnet, Professor R. D. Wright, Professor H. K. Ward and the Director-General of Health. As noted in THE MEDICAL JOURNAL OF AUSTRALIA of October 5, 1946, at page 493, the members of the Technical Advisory Committee had, with other members of the National Health and Medical Research Council, been appointed as members of the Medical Research Advisory Committee of the council. The President said that he had, on reading the Acting Director-General's letter to Dr. Simmons, suggested that an institute of hygiene at Canberra should be used for the purposes of training personnel for public health services. Dr. A. E. Lee had written, pointing out that the Medical Research Advisory Committee was not composed entirely of research men and was inferior to a separate medical research council. The Queensland Branch had stated in a letter that it was in favour of the principle of a separate body to control research. Dr. W. F. Simmons said that as far as he knew, Sir Howard Florey and Professor Oliphant were coming to Australia. The correspondence was received.

Tuberculosis.

The General Secretary stated that in accordance with a resolution of the Federal Council he had written to the Prime Minister in April, 1946, expressing regret that the Government had failed to make provision in the *Tuberculosis Act*, 1945, for the payment to sufferers from tuberculosis of a pension equal in amount to that paid to similar sufferers entitled to the benefits of the *Repatriation Act*. The letter pointed out that in order that the sufferer might be induced to submit himself for examination and treatment at the earliest possible moment, it was essential that he should not be worried regarding the economic welfare of himself and his dependants. The Council therefore urged that consideration should be given to the amending of the *Tuberculosis Act*, providing for payment of a pension not less than that paid to beneficiaries under the *Repatriation Act*. A reply had been received after seven days, stating that consideration would be given to the Federal Council's representations. In September, 1946, the Acting General Secretary of the Federal Council had written to the Prime Minister, asking whether any decisions had been arrived at in the matter. The Prime Minister had replied on October 4, stating that the *Tuberculosis Act*, 1945, had been amended by passage of the *Tuberculosis Act*, 1946. In the latter act the following section had replaced a section of the 1945 act:

6. (1) An amount determined in accordance with this section shall be payable in every year to each State upon the condition that the amount is applied by the State during that year in making payments to or in respect of sufferers from tuberculosis, or the dependants of such sufferers, with the objects of—(a) encouraging such sufferers to refrain from working and to take treatment; (b) minimizing the spread of tuberculosis; and (c) promoting the better treatment of tuberculosis.

(2) The amounts payable to the States under this section shall be determined by the Minister, but shall not exceed in the aggregate in any year the sum of two hundred and fifty thousand pounds.

(3) The Treasurer may pay to the Minister such amounts as are agreed upon between the Treasurer and the Minister for the purpose of the making of payments to or in respect of sufferers from tuberculosis, or the dependants of such sufferers, in the Australian Capital Territory and the Northern Territory with the same objects as are specified in this section in relation to payments by the States, and the Minister may make payments accordingly out of the sums so paid to him by the Treasurer.

(4) A payment received by a person out of moneys (a) paid to a State or to the Minister under this section; or (b) provided by a State for the objects for which payments may be made by a State under this section, shall be deemed not to be income for the purposes of the *Invalid and Old-Age Pensions Act, 1908-1946*, the *Widow's Pension Act, 1942-1946*, and the *Unemployment and Sickness Benefits Act, 1944*.

The Prime Minister's letter went on to explain that the sum of £250,000 would be divided amongst the States in a manner approved by the Minister for Health. The amount had been allotted to the States, half on a population basis and the other half in accordance with the incidence of tuberculosis in each State. The Commonwealth had not provided any regulations under the *Tuberculosis Act*, and the distribution of the money had been left entirely to the State Governments. The grant was in addition to the £100,000 *per annum* made available to the States for the maintenance of diagnostic and after-care facilities as provided in the *Tuberculosis Act, 1945*.

In the discussion that followed, it was pointed out that Queensland was at present the only State in which satisfactory payments were made to sufferers from tuberculosis. Dr. H. R. R. Grieve said that this was a matter that should be made public. He agreed that the steps taken were quite inadequate. There was no doubt in his mind that the provision of treatment for tuberculosis sufferers was a government responsibility. Dr. W. F. Simmons agreed with Dr. Grieve's views and referred to the activities of Dr. D. R. W. Cowan, of Adelaide, in regard to the establishment of a Commonwealth tuberculosis campaign. The President expressed his concordance with these views, and referred to the advisability of the establishment of a national association for the prevention of tuberculosis in Australia. It was then decided that a statement should be submitted to the daily Press. The statement was as follows:

The Federal Council of the British Medical Association meeting in Adelaide is seriously concerned at the evidences of failure by governments, Commonwealth and State, to effectuate essential measures for the control of tuberculosis. During the past ten years the Federal Council intimated to successive governments that the necessary plans are such as can only be carried out by governments, and in 1944 that such plans should be given first priority in the health and social service programmes.

Two main elements of policy are indispensable. The first is the provision of nothing less than a living wage allowance for breadwinner sufferers, and the second the construction, equipment and staffing of adequate sanatoria. In no State of the Commonwealth, except Queensland, is an allowance of the standard of living wage made to breadwinner sufferers. Throughout Australia there is a lack of sanatorium accommodation, which is tragic. It is within the knowledge of the Federal Council that sufferers who have been discovered early and whose lives could be saved by sanatorium treatment are dying for lack of it. It is also known to the Federal Council that sufferers, whose disease could be controlled by rest and freedom from want, are deteriorating because in the absence of a living wage allowance they find it necessary to carry on at work—often strenuous work. Meanwhile infection continues to be spread.

Grants recently made to the State Government by the Federal Government for an anti-tuberculosis campaign were absurdly inadequate. The position has been reached where certain governments cannot escape responsibility for the loss and deterioration of lives.

The Federal Council of the British Medical Association now feels impelled to inform the public of Australia that first priority in a public health campaign should be the construction, equipment and staffing of sufficient sanatoria, and the first priority in social services, the granting of a living wage allowance to breadwinner sufferers from tuberculosis.

Nomenclature of Drugs.

After the previous meeting of the Federal Council a request was forwarded to the Acting Director-General of Health of the Commonwealth from the Federal Council that the National Health and Medical Research Council should give consideration to the appointment of a committee of reference to deal with the nomenclature of drugs. The General Secretary reported that he had received a reply from the Acting Director-General in June, 1946, to the effect that the nomenclature of British Pharmacopoeia and other drugs was under discussion in both England and America, and that the rapidly increasing number of proprietary packs lent urgency to the question. The British Pharmacopoeia Commission had set up a special committee to deal with this matter, and already the policy of providing approved names for old and new drugs was operating. The Acting Director-General stated that in view of these facts, the National Health and Medical Research Council decided that no good purpose would be served by setting up a special commission in Australia, since the British Pharmacopoeia Commission was an authoritative body, and it would be desirable for Australia to wait for the publication of the commission's recommendations.

In connexion with this matter the Federal Council received a deputation from the Pharmaceutical Association of Australia and New Zealand. The leader of the deputation, Mr. K. S. Potter, President of the Pharmaceutical Association of Australia and New Zealand, read to the Federal Council an article by Dr. Byron L. Stanton dealing with the multiplicity of proprietary names for pure drugs. In this article Dr. Stanton advanced many reasons why the present state of affairs should not be tolerated. Dr. Stanton then quoted the following paragraph from a pamphlet issued by the General Medical Council of Great Britain:

Since the intention is to give recognition to non-proprietary names which may be used freely by manufacturers, and thus to avoid the difficulties which arise from the multiplication of names for the same substance, it is hoped that the Approved Names will be generally adopted and used in prescribing. The introduction of new names for substances for which Pharmacopoeial names or Approved Names are available is especially deprecated, and if a manufacturer desires to issue under a proprietary name a drug for which an Approved Name has been provided, it is strongly recommended that the label shall bear the Approved Name of the substance in letters no less conspicuous than those in which the proprietary name is printed or written.

Dr. Stanton then suggested the following remedies: (i) that the only title allowed for a drug should be its pharmacopoeial or its "approved" name; (ii) that if the drug was in general use, but not included in the list of official or approved names, a suitable descriptive name should be approved by some competent Commonwealth body; (iii) that if the concession of a proprietary name was allowed, the propositions of the General Medical Council quoted above should be adopted; (iv) that no advertising claims should be allowed which indicated that the drug under a specific proprietary name had any special claim to therapeutic superiority; (v) that in conjunction with the British Medical Association the Pharmaceutical Conference should take measures to give legal force to a proposition of this kind on which agreement had been reached.

Australian Pharmaceutical Formulary.

The General Secretary reported that an Editorial Committee and a Publications Committee had been appointed for the revision of the Australian Pharmaceutical Formulary, and that a preliminary draft had been drawn up.

The Proprietary Medicines Investigation Committee.

Reference was made to a complaint by the Victorian Branch to the Proprietary Medicines Investigation Committee in regard to certain advertisements which, in the

opinion of the Victorian Branch, were misleading. The General Secretary said that the matter had been taken up with Dr. A. J. Collins, who was the Federal Council's representative on this investigation committee. Dr. Collins was of the opinion that, although it was slow, progress was being made. A number of matters had been submitted for adjudication to himself, Dr. Adrien Albert and the Acting Director-General of Health. Dr. Collins thought that as time went on, more products would be referred to the committee.

Taxation on Scholarships.

Further reference was made to the income tax payable by Fellows holding overseas travelling scholarships. The General Secretary read a letter which had been received by Dr. W. F. Simmons, the Federal Council's representative on the National Health and Medical Research Council. This letter was written by the Deputy Commissioner of Taxation to the Director-General of Health, and was to the effect that consideration had been given to the Nuffield, Rockefeller and Carnegie Trust Fellowships and the payment of income tax on the grants from those foundations. The Income Tax Commissioner had decided that the grants fell within the third class of special cases referred to in a letter by the Treasurer to the Minister for Health and Social Services. The conclusion was that the expenditure incurred by the holder of any of these fellowships in fulfilment of the terms under which the fellowship was granted to him, was comparable with expenditure incurred by any other professional man in travelling abroad for the purpose of maintaining his professional status. The Commonwealth Taxation Board of Review had decided that expenditure of the last-mentioned kind was an allowable deduction for income tax purposes. This meant that the holder of a Nuffield, Rockefeller or Carnegie Trust Fellowship would be allowed a deduction of all expenditure (not exceeding the amount received by him under the fellowship) incurred by him in fulfilment of the terms under which the fellowship was granted. The amount to be allowed would include *inter alia* the cost of textbooks and equipment, tuition, travelling, board and accommodation while abroad.

Supplies of Penicillin.

The General Secretary reported that a request had been received from the Queensland Branch that steps should be taken to facilitate the obtaining of holiday and week-end supplies of penicillin, and also that the form at present necessary for obtaining supplies of penicillin should be abolished. The General Secretary went on to say that since receipt of the letter from the Queensland Branch the National Security regulation governing penicillin had been revoked, as a result of which no form was now necessary for obtaining supplies of penicillin. He also said that because of increased supplies the price of penicillin had been reduced and very little difficulty was being experienced by medical practitioners in obtaining adequate supplies. Following a discussion later with representatives of the Pharmaceutical Association of Australia and New Zealand it was resolved that the Branches should be advised that it was essential that when the National Security Regulations were repealed, State Health Departments should be asked to insure that penicillin could be obtained only on the prescription of a legally qualified medical practitioner, dentist or veterinary surgeon.

Supplies of Rice.

A letter was received from the Queensland Branch, suggesting that a request should be forwarded to the Federal Government asking that the sale of rice should be forbidden in Australia in any circumstances except as a strict ration to those people for whom it constituted a staple food. The Queensland Branch held that to the Australian rice was merely a luxury, but that to millions of people overseas it was a necessity, and they were dying for lack of it. In regard to nutrition, there were perfectly satisfactory substitutes in Australia, and the fact that Australians wanted to retain a luxury food was no justification for its use. At the present time also, medical men were constantly being badgered for certificates for the supply of rice to invalids. This was very unpleasant, and the only way to stop it was for the Government to announce that certificates given in this way would be disregarded. When the opinion of one of the Branches was stated, that the question of the supply of meat to Britain was a much more important subject, Dr. H. W. Horn said that this was not a frivolous matter. In Queensland rice was obtainable by Dutchmen and others. He pressed the Queensland point of view. It was therefore resolved that the subject matter of the letter forwarded by the Queensland Branch should be referred to the responsible Commonwealth Minister.

Income Tax Deductions: Depreciation of Books.

A letter was received from the New South Wales Branch, in which it was stated that the present allowance of 5% on the value of books for purposes of income tax deductions was totally inadequate. It thought that an allowance of 25% would be more equitable. In support of this view the Council pointed out that in many cases the value of a book depreciated to a considerable extent as soon as a new edition was published. It was resolved that a request should be made to the Commissioner for Taxation that the amount allowed for depreciation on books for income tax purposes should be increased from 5% to 20%.

Industrial Accident Records.

The General Secretary laid on the table the copy of a booklet issued by the Department of Labour and National Service, Industrial Welfare Division, on the compilation use of industrial accident records. This brochure was the subject of a short editorial in the issue of August 17, 1946.

The Determination of Specialties and the Registration of Specialists.

A request was received from the Western Australian Branch, asking for opinions and suggestions which would assist the Branch in advising the Medical Board of Western Australia in regard to the determination of specialties and the registration of specialists under the *Hospital Act Amendment Act of Western Australia, 1945*. The General Secretary said that correspondence had passed between Dr. A. E. Lee and Dr. H. W. Horn, of Queensland, and the Western Australian Branch. Dr. Lee and Dr. Horn had explained the operation of the *Medical Act* in Queensland as it affected the registration of specialists. The General Secretary also explained that in Great Britain consideration was being given to amending *The Medical Act* so as to provide for the registration of specialists. He understood that the act would lay down the qualifications of a specialist, but that no attempt would be made to name individuals as specialists. There would be no attempt to limit the activities of a practitioner. This decision would be of assistance to hospital authorities by implication.

Fees for Medical Examinations.

At the previous meeting of the Federal Council reference was made to the fees paid for the medical examination of candidates for entrance to the service of the Commonwealth Bank of Australia. The General Secretary said that following the previous discussions he had written to the Acting Director-General of Health and to the Governor of the Commonwealth Bank, pointing out that the fee of half a guinea paid to medical practitioners for the examination of candidates for the bank's service was inadequate. The view was expressed that because of the detailed form which had to be completed, the fee paid should be not less than that paid by insurance companies and other bodies for similar examinations—namely, one guinea. A reply had been received from the Governor of the Commonwealth Bank, stating that having regard to all the circumstances the bank had decided to adopt the same type of form as was used for Commonwealth Public Service candidates. According to this arrangement, Commonwealth medical officers would not in future be required to put the question to candidates in regard to personal and family history, or to fill in the answers. The candidates would have this section of the form completed before their visit to the doctor. A uniform fee of half a guinea would then be paid by both the Commonwealth Bank and the Commonwealth Public Service for uniform types of examination. The Federal Council discussed the examination which would have to be made before the form was completed by the examiner, and resolved that the General Secretary should take up the matter with the Chairman of the Commonwealth Public Service Board, and that he should be informed that the Federal Council considered the fee for examination of candidates for entrance to the Public Service to be totally inadequate, and that the fee should be not less than one guinea. The General Secretary also said that in accordance with the decision of the Federal Council at a previous meeting, he had written to the Life Offices Association of Australasia, asking that when the examination of a candidate for assurance required the use of the extended form, the fee for such examination should be two guineas. He said that he had received a reply, stating that the Life Offices Association of Australasia was considering the practicability of standardizing medical examination reports, which, it was undisputed, would materially reduce the time and work involved in the completion of medical examinations.

Telephone Directories.

At the previous meeting of the Federal Council it was resolved that in view of the fact that many members of the medical profession, who had been in the armed services, would be resuming or commencing practice soon after the issue of the telephone directory, the Postmaster-General's Department should be requested to give consideration to the issue of monthly supplementary lists containing new and altered telephone numbers. A reply had been received from the Postmaster-General indicating that it would not be possible to adopt the suggestion of the Federal Council. The General Secretary said that a letter had been received from the Victorian Branch, suggesting that the application should be renewed. Dr. W. F. Simmons pointed out that according to information received the telephone directories would in future be issued twice a year. After discussion it was resolved that as from January, 1947, telephone directories would be issued twice a year, no further action should be taken, and that the Victorian Branch should be advised accordingly.

The Salaries of Commonwealth Medical Officers.

At the previous meeting of the Federal Council a discussion took place on the range of the salaries of Commonwealth medical officers. The several grades in the service were discussed, and certain conclusions regarding range of salaries were reached. The General Secretary said that he had written and told the Commonwealth Medical Officers' Association of the Federal Council's decision. He said that the medical officers' application had gone before the Commonwealth Public Service Arbitrator. An increase had been granted, though it was not as large as the association had hoped to receive.

The Conditions of Service of Full-Time Medical Officers of the Permanent Armed Forces.

Further consideration was given by the Federal Council to the conditions of service of medical officers serving with the Royal Australian Navy. The General Secretary read a letter which had come from the Navy Office, drawing attention to the great difficulty that was being experienced in securing medical officers for the navy, both for the interim period and for the permanent service. The matter of rates of pay and conditions of service generally in the post-war services was under consideration. At the present time wartime conditions still operated in the three services' interim forces. The Naval Board had appointed a committee to report (a) about the reasons which had given rise to the present situation and (b) about the steps that might be necessary to overcome it. The Naval Board wished the Federal Council to nominate a suitable representative who would be prepared to give the new committee the benefit of his opinion. The General Secretary said that Sir Alan Newton had been invited to act as a member of the committee, and that he had agreed to do so. In discussion the Federal Council agreed that if the terms and conditions of service were made acceptable, a great deal of the trouble experienced by the Royal Australian Navy would vanish.

War Emergency Organization.

Conditions of Service Committee.

It was resolved that Dr. W. F. Simmons and Dr. H. R. R. Grieve should be appointed members of the Conditions of Service Committee.

Repatriation Commission.

Reference was made to the medical benefits for widows, orphans and widowed mothers of the 1939-1945 war, and to the inability of the Repatriation Commission to commence the scheme in Queensland owing to the lack of response from medical practitioners. In discussion it was suggested that a further effort should be made by the Queensland Branch to prevail upon its members to undertake this work. Dr. H. W. Horn explained that so far all appeals from the Branch Council had been unavailing. It was resolved that the Queensland Branch should be asked to take up with its members the matter of the supply of medical services to the widows and orphans entitled to repatriation benefits, and that the Branch should be told that the Federal Council regarded the matter as urgent.

The Federal Council discussed the extension of the local medical officer system in the out-patient treatment of ex-service personnel with accepted war disabilities. A conference with representatives of the Repatriation Commission had been held in May, 1946, and the General Secretary read a letter from the Chairman of the Commission dated July 11, 1946, in which it was stated that the panel for repatriation local medical officers, both for country districts and in the

metropolitan areas of capital cities, would be compiled from all registered medical practitioners who were natural born British subjects or naturalized British subjects, who were willing to accept appointment as local medical officers and to abide by the conditions of appointment. To be included in the panel it would be necessary for a medical practitioner to make application to the Deputy Commissioner of Repatriation in the capital city of the State in which he practised, and to be approved by the Commission. The fees to be paid for services rendered by local medical officers would be as laid down in the booklet, "Instructions for Local Medical Officers", subject, of course, to any amendment which might be decided upon in consequence of the Federal Council's representations, which were receiving consideration. The General Secretary referred to fees payable to local medical officers for out-patient treatment and to the proposal that they should be increased. He said that the matter was still under consideration, and that no decision had been made. After discussion the Federal Council adopted the following resolution:

That the Federal Council is of the opinion that the rate of payment for part-time repatriation medical officers should be not less than £5 5s. for a session of not more than three hours, and that mileage should be paid at the rate of 5s. per mile one way after two miles from the medical officer's usual place of practice.

The General Secretary drew attention to a proposal of the Queensland Branch that the forms used by repatriation medical officers should be simplified, and that a schedule of fees should be drawn up. He said that a report on the matter by the Queensland Branch Council had been submitted to the Branches. The Victorian, New South Wales and South Australian Branches had agreed with the Queensland proposal. The idea was that the procedure should be so simplified that anything pertaining to one patient could be included in one form, with perhaps a separate form for prescription and a claim for fees. It was resolved on the motion of Dr. H. W. Horn that the matter should be taken up with the department, and it was left in the hands of Dr. F. L. Davies. The General Secretary further reported that the Commission had agreed to an amendment of form M.F. 9A, used for the examination of a soldier for the acceptance of a condition as attributable to war service. The Commission had also agreed to an increase in payment from 10s. to 21s. The matter was noted. It was also resolved that Dr. Davies should take up with the Commission the matter of the qualification certificate, form M 83, used in connexion with war service land settlement. It was proposed that the fee paid to local medical officers for completion of the form should be increased from 10s. to 21s. The Federal Council also noted that a Special Advisory Committee on Medical Services had visited the capital cities on behalf of the Repatriation Commission in connexion with a scheme of reorganization. The views of the Branches had been submitted to this committee. The committee consisted of Colonel E. J. Parkes, chairman, with Major-General S. R. Burston, Air Vice-Marshal T. E. Victor Hurley and Colonel Kenneth Smith as members.

Rehabilitation of Medical Officers in the Armed Forces.

The General Secretary said that a request had been made to the Minister for Post-War Reconstruction in regard to the Commonwealth Reconstruction Training Scheme. The Minister had been asked that the benefits of the scheme should be extended to ex-service medical officers proceeding overseas for post-graduate study. A reply had been received from the Minister, pointing out that a scheme of post-graduate training had been approved by Cabinet, but that those eligible to participate in benefits for training had to come within the normal categories of eligibility. In general the type of persons most concerned were those who had enlisted when under twenty-one years of age, and who because of war-caused incapacity or incapacity existing at the date of discharge were unable to return to their pre-war occupation. The post-graduate scheme was also competitive and was therefore restricted to outstanding graduates chosen for their special qualifications for courses not available in Australia, or who could give special reasons for training abroad. Under the scheme selected applicants had their return fares paid together with fees and a living allowance. The Minister further explained that in addition to the post-graduate scheme, application might be made for refresher training, but that if the training was sought abroad the course had to be unavailable in Australia. Graduates selected for this type of training received only the sterling equivalent of fees and other allowances payable had the training been undertaken in Australia. They also

had themselves to bear the cost of their return passage to the Commonwealth. The Federal Council noted that overseas travelling fellowships had been awarded to discharged medical officers, and recorded its appreciation of Major-General Burston's efforts in the arranging of the provisions for these scholarships.

The General Secretary also referred to correspondence that had taken place between himself and the Minister for Immigration, the Honourable A. A. Calwell. A letter had been written to the Minister expressing the view that it was highly desirable in the public interest that medical practitioners should be permitted to further their education by visiting centres of learning in other parts of the world. The Federal Council was of opinion that the supply of medical practitioners was now such that no unreasonable difficulties should be placed in the way of those, especially ex-service medical officers, who wished to proceed overseas for post-graduate study. The Minister had replied that he agreed with the general principle expressed in the Federal Council's letter, but that he did not agree that the supply of medical practitioners was such that no unreasonable difficulties should be placed in the way of those who wished to proceed overseas for post-graduate study. His advice was that the supply of medical practitioners was not yet sufficient to meet the needs of the community. In view of a Cabinet decision, passports were not to be granted except in special circumstances to doctors to enable them to leave Australia until sufficient numbers had been discharged to meet the needs of the community. As the Medical Coordination Committee had been disbanded, the Minister proposed to continue for the present the practice of requiring each application to be dealt with on its merits. As a rule permission would be granted to enable a doctor to proceed abroad for post-graduate study, provided he had made definite arrangements for such study at some hospital or university and produced evidence to that effect. In further reference to the Federal Council's opinion, the Minister wished to inform the Council that no "unreasonable difficulties" had ever been placed in the way of any doctor desiring to leave Australia, that the law was fairly and justly administered, and that the requirements which had been laid down in the national interest were not difficulties except to those who had no right to consideration.

Civil Professional Rooms for Demobilized Service Medical Officers.

The General Secretary said that he had written to the Minister for Works and Housing in connexion with the difficulties which were experienced by ex-service medical officers in obtaining professional accommodation. He had suggested to the Minister that certain amendments might be made to the Landlord and Tenant Regulations, so that the hardships of ex-service medical officers would be minimized. The Minister had replied in October, 1946, that at the last Premiers' Conference it had been decided that control over eviction proceedings should be continued, and that steps should be taken towards the end of the current year to introduce substantive legislation to replace existing regulations. The Minister went on to state that in the preparation of such legislation it was proposed to give full consideration to the question of assistance to be afforded to ex-servicemen in regard to professional or business premises, and that due weight would be given to the Federal Council's representation in this regard.

Rates of Pay for Part-Time Duty with the Australian Army Medical Corps.

At previous meetings of the Federal Council, objection had been taken to the rates of payment offered to officers of the Australian Army Medical Corps not called up for full-time war service and to civilian medical practitioners. The General Secretary read extracts from the correspondence which dated from November, 1945. The latest communication was a letter from the Director-General of Medical Services bearing the date September 13, 1946, in which it was stated that recent approval by the Treasury provided for the payment of specialists and general practitioners attending army hospitals at the rates authorized for payment by the Repatriation Commission. A recommendation for a general revision of the allowances payable for all types of professional service rendered by medical practitioners had also been submitted and was under consideration.

Fees for Examination of Recruits to the Army.

The General Secretary read a reply from the Director-General of Medical Services to a letter from the Federal Council asking that the fee for a single examination of a recruit to the army should be 10s. 6d., and that when a

number of examinations were carried out at area headquarters the fee should be two guineas per session not exceeding three hours. The Director-General stated in his reply that the payment of the fee of 2s. 6d. per recruit had been discontinued on the introduction of War Finance Regulations. Payment for this service at the present time was at the rate of £1 5s. if the period of duty was three hours or more and 12s. 6d. if the period of duty was less than three hours. Some time previously a recommendation had been submitted for the increase of these rates to two guineas if the period of duty was three hours or more and one guinea if the period was less than three hours. No decision had yet been given by the Treasury.

Repeal of Regulations Relating to the Control of Medical Practitioners.

The General Secretary read a letter from Senator J. M. Fraser, who was Minister for Health at the time when the regulations relating to the control of medical practitioners were repealed, addressed to the President of the Federal Council, expressing appreciation of the Commonwealth Government for the services rendered by the medical profession to the community during the war period. In his reply to the Minister, the President remarked that the medical profession had voluntarily submitted to a form of conscription which was applied to no other professional body. That the control worked so well was, as the Minister had testified, due to the praiseworthy efficiency of the Medical Coordination Committees.

Instruments for Discharged Medical Officers.

Reference was made to the arrangements that were to have been made for the purchase by the Repatriation Commission of surplus medical instruments from the Commonwealth Disposals Commission and for their resale to ex-service medical officers. A request had been received from the Central Medical Coordination Committee for information regarding instruments required. It was reported that no results had been obtained from the arrangement.

The Rehabilitation of Ex-Service Personnel with a Disability Not Accepted as Related to War Service.

The General Secretary, in opening the discussion on the rehabilitation of ex-service personnel with a disability not accepted as being related to war service, said that an invitation had been received from Dr. Douglas Galbraith, the Coordinator of Rehabilitation, asking the Federal Council to send representatives to attend meetings of the Commonwealth Interdepartmental Committee on Disablement in Melbourne on August 30 and September 5, 1946. The invitation had been received at very short notice, and fortunately Dr. F. L. Davies was able to accept it. The General Secretary laid before the members of the Federal Council various documents dealing with the proposal. Readers will find a general discussion of the subject in a paper entitled "The Responsibility of the Doctor in Regard to Rehabilitation in Private and Hospital Practice", read by Dr. Douglas Galbraith to the Victorian Branch in March, 1946, and published in THE MEDICAL JOURNAL OF AUSTRALIA of July 6, 1946, at page 1. The General Secretary also said that arrangements had been made for Dr. Galbraith to address the Federal Council. Dr. Galbraith attended and gave an outline of what the Ministry of Post-War Reconstruction proposed to do, and answered questions put to him by members of the Council. The following summary of the plan is taken from a letter written by Dr. Galbraith to the Federal Council on August 23, 1946.

(i) Any ex-member of the Forces who has a disability, but who has not been accepted for war pension and medical treatment benefits for the main disabling condition, may apply to the Department of Social Services for treatment, which may include hospital treatment, convalescent or rehabilitation treatment, pre-vocational and vocational training for selective employment. Such applications will be decided in consultation with administrative, medical, training and employment authorities.

(ii) In respect of those ex-members whose illness or injury (non-war caused) precludes full and early resumption of their normal occupations, and who may be made fit for full or partial employment, the Department of Social Services may provide or enter into arrangements with other authorities to provide the treatment designated in (i) above. A general plan of additional facilities which it is necessary to establish is to be submitted for Treasury concurrence.

This provision will operate until 30th June, 1946, in respect of those discharged before 1st July, 1946, or

for a period of 12 months after discharge in the case of those discharged after 1st July, 1946.

(iii) While undergoing treatment or training or awaiting suitable employment, the ex-member may be paid allowances at the same rates as under the Interim Scheme for a maximum period of 12 months provided that a re-employment allowance will not be payable for any period in excess of 6 months and any re-employment payment already paid under the Re-establishment and Employment Act will be taken into account in determining the maximum period of 6 months.

(iv) In general in regard to training, the planning of such training will be the responsibility of the Department of Social Services and the Repatriation Commission in consultation. The provision or arranging for provision of training will be the responsibility of the Industrial Training Division of the Department of Labour and National Service.

(v) Any ex-member who because of a disability is substantially handicapped in obtaining or maintaining himself in employment, may apply to be registered for selective employment when he will become eligible for payment of the re-employment allowance. Any ex-member receiving treatment under (i) above would not be placed upon the Register until he is ready for employment.

After Dr. Galbraith had retired from the meeting, the Federal Council discussed the proposal. The General Secretary said that the question had been referred to the Branches, and that Dr. Galbraith had addressed several Branch Councils. The New South Wales Branch was opposed to the idea. Dr. F. L. Davies expressed the opinion that the Federal Council must cooperate. In explaining the New South Wales attitude, Dr. H. R. R. Grieve said that the idea was wrong in principle. It was thought that repatriation medical officers should not be called upon to treat people of the category described. There was no knowing where such a proposal, if carried into effect, would lead. There were upwards of 600,000 discharged service personnel. When their disability was not due to war service, they were looked after in the community in the ordinary way. This was an attempt to create a new department with a great deal of top hamper, and to take men from the doctors who were looking after them. Dr. Simmons said that he did not like the idea, and he thought that in ten months the whole affair would be taken up by the Social Services Department. Dr. A. E. Lee thought that the profession could not draw back. They were faced with a position in which an estimable piece of rehabilitation was offered. If the profession opposed this now, they were opposing something that was good, provided that it was kept within limits. He thought that the best terms and conditions should be obtained, and also expressed the view that it would be impossible to oppose the scheme later in its development. What worried him were the terms and conditions of any scheme of visiting medical practice. Dr. H. W. Horn agreed with Dr. Davies that the remedy was not to oppose the scheme. He was opposed to the treatment of people who would otherwise go to hospital. The patient should be able to choose his own doctor, and should not necessarily be sent to a special hospital. Dr. W. F. Simmons pointed out that in repatriation work the Federal Council had established the right of the patient to the choice of his own doctor. Dr. N. M. Cuthbert said that the profession should cooperate if the terms were right and the patient was allowed to choose his doctor. Dr. Victor Hurley traced the sequence of events that had led up to the development of this proposal. He said that some organization was necessary to rehabilitate ex-servicemen, and the Government must have advice and assistance in the matter. Any political party would have established the organization described by Dr. Galbraith, and at some stage the Government would have to come to the medical profession. It seemed to him that a government had the right to decide that a certain thing should be done. The medical profession in this matter was asked to mark its own ticket. If essential principles were safeguarded, he did not see how the medical profession could refuse. The President said that the suspicions voiced by Dr. Grieve and Dr. Simmons had entered all their minds, but these suspicions were not necessarily justified. All ex-service people should have the means of being restored to industry. The Federal Council asked for hospitals and sanatoria for the tuberculous. It must also ask for the development of suitable methods of rehabilitation. A workshop which was being established for the tuberculous, and to which the President had referred in connexion with another matter, was an example of what could be done. Dr. H. R. R. Grieve said that an

institution somewhat similar to the workshop type of arrangement mentioned by the President was what he had had in mind. He thought that a committee of the Federal Council might report on the matter. Dr. Grieve remarked that a report on the rehabilitation of persons not suffering from war disability had been drawn up some months before by the New South Wales Branch. After further discussion it was resolved that a committee of the Federal Council should be appointed to report on the matter.

Australian Medical Officers in the Army of Occupation in Japan.

Reference was made to the difficulties that were being experienced in obtaining volunteer medical officers to serve in the Australian Army Medical Corps during the post-war period. This was particularly noticeable in regard to the Army of Occupation in Japan. The General Secretary read some correspondence that had passed between the President and the Director-General of Medical Services. The view was expressed by members of the Federal Council that the difficulties would not be great if the remuneration and conditions of service were acceptable. It was resolved that the Director-General should be invited to submit a statement for publication in THE MEDICAL JOURNAL OF AUSTRALIA.

Principles of Medical Ethics.

At the previous meeting of the Federal Council it was resolved that a committee should go into the question of drawing up a code of medical ethics. The General Secretary reported that owing to his absence in England on the Federal Council's business, it had been impossible for him to proceed with the matter. Consideration was therefore deferred.

Australasian Medical Congress (British Medical Association).

Reference was made to the resumption of sessions of the Australasian Medical Congress (British Medical Association). Dr. F. W. Carter said that the Western Australian Branch was still anxious that the next session of congress should be held in Perth. He added that at the next meeting of the Federal Council the Western Australian Branch would issue a formal invitation to the Federal Council to hold a congress at Perth in 1948, provided no other Branch wished to issue an invitation.

Date and Place of the Next Meeting.

It was resolved that the date and place of the next meeting should be left in the hands of the President.

Votes of Thanks.

Votes of thanks were passed to the South Australian Branch Council, to Sir Henry Newland and to Dr. R. J. Verco for their hospitality, and to the South Australian Branch for the use of its offices. The thanks of the Council were also extended to the President for presiding.

VICTORIAN BRANCH NEWS.

THE RESULT OF THE BALLOT FOR THE 1947 COUNCIL.

THE following information on the result of the ballot for the 1947 Council of the Victorian Branch of the British Medical Association is published at the request of the Medical Secretary.

Place.	Name.	No. of Votes.
1.	Hurley, Victor	528
2.	Coates, A. E.	527
3.	Green, John S.	519
4.	MacCallum, Professor P.	516
5.	Norris, F. Kingsley	512
6.	Southby, Robert	511
7.	Dale, John	505
8.	Colville, H. Cecil	488
9.	Johnston, Leonard W.	461
10.	Brown, Arthur	440
11.	Byrne, Charles	413
12.	Thomas, D. J.	400
13.	Gowland, John H.	391
14.	Smith, Kenneth	380
15.	Furnell, H. G.	372
16.	Sinclair, Alex. J. M.	332
17.	Morris, G. Newman	293
	Votes counted	542
	Informal	7

NOTICE.

THE General Secretary of the Federal Council of the British Medical Association in Australia has announced that the following medical practitioner has been released from full-time duty with His Majesty's Forces and has resumed civil practice as from the date mentioned:

Dr. D. Officer Brown, 135, Macquarie Street, Sydney (June 3, 1946).

Correspondence.

HEADACHES AS A SYNDROME OF WAR NEUROSES.

SIR: I have read many articles in the medical journals recently regarding war neuroses, but none of them have stressed headache as the main complaint of the patient. From my experience of nerve cases in the Navy since the beginning of this war, including anxiety states, debility following long and arduous war service at sea and in the tropics *et cetera*, the patient, when asked what he is complaining of, invariably gives headaches as the predominant symptom.

The "*morbus cordis functionalis*" has certainly vanished as an entity in this war, and although functional dyspepsias are common, the much more universal complaint common to all is this headache—very often the only symptom.

Most of these patients are referred to the ophthalmologist, and it is interesting to record how few of them have a refractive error which could account for the symptoms. Too many of them are given glasses with a small refractive correction in the vain hope that the headaches may vanish. Within a few months they are sent to another ophthalmologist, still with their headaches and bitterly complaining that the glasses are no good. One patient of mine, who was given glasses for myopic astigmatism some years ago, was recently seen by an ophthalmologist and the glasses were changed. When I saw him a few months later, I found that the original correction was the more suitable one, and I asked him why he got his glasses changed. His reply was, that he reported complaining of severe headaches of which he wanted to know the cause, and not for a change of glasses. In his case he had completed seven years of solid hard sea service in extremely hot conditions with very little leave, and he was suffering from definite nervous debility and exhaustion. A six months period away from the tropics at his home depot accomplished wonders, and when he was asked about his headaches at the end of this period he said that they were practically non-existent. Incidentally he was wearing his original glasses.

Yours, etc.,

H. W. GAULT,
Surgeon Commander, Royal
Australian Navy.

Department of the Navy,
Melbourne,
November 7, 1946.

AN OBSCURE EXAMINATION QUESTION.

SIR: In the physiology paper for the Master of Surgery degree, November 26, 1946, this question appeared:

Demonstrate your knowledge of basic physiological principles by discussing the extent and significance of physiological margins in circulatory phenomena, selecting among other items for discussion, anastomoses (actual and potential), vasomotor control, oxygen capacity of the blood, etc.

What the above literary farrago accurately means only the examiner knows. What it could mean is diffuse conjecture. He is apparently asking for definite information ("extent and significance") within undefined limits ("margins"). He disperses the question still further by nominating three mechanisms for discussion and then, alas, adds "etc."

Now, "margin", unless it has been endowed with a special physiological significance (of which I am unaware and can find no reference), means "boundary", "that allowed beyond what is necessary", "confine", "close limits". What, then, are the boundaries of physiology? Pathology, death, hydrostatics, psychology, statistics? How can physiology, the

science of vital processes of life, be confined by boundaries or close limits without qualifications stated? I cannot even pretend to guess. How the examinees guessed or why they were expected to, are powerful questions. It is enough to make anyone "marginal"; more than enough for one under examination stress.

Adding chaos to obscurity, the examiner inserts the delicate redundancy "among other items", followed, as noted above, by "etc."

Surely, for a senior degree, it is not too much to expect a clear question if a clear answer is required.

As one who has suffered some academic inconvenience from vague half-stated questions (requiring, of course, accurately stated answers), I am goaded to protest both in retrospect and prospect.

I must add that I did not sit for the examination.

Yours, etc.,

J. E. M. STOREY.

Quirindi,
New South Wales,
December 2, 1946.

INOPERABLE MALIGNANT DISEASE OF BREAST, UTERUS AND OVARY.

SIR: Could I please request most humbly through your columns that cases of malignant neoplasm of the breast, uterus and ovary which are inoperable and which have given post-operative metastases be treated with Lugol's solution and thiouracil, and the results, if any, recorded?

Yours, etc.,

J. M. O'CONNOR.

National Mutual Building,
293, Queen Street,
Brisbane.
December 4, 1946.

Post-Graduate Work.

THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

POST-GRADUATE COURSES, 1947.

THE Post-Graduate Committee in Medicine announces the following courses, which are open to all medical practitioners.

Courses for General Practitioners.

A course for general practitioners will be held from January 13 to April 3, 1947. It is likely that a further course of three months' duration will begin on April 14.

Degree and Diploma Courses.

Courses in advanced medicine (suitable for candidates for the M.R.A.C.P. examination), January 13 to April 3 and June 9 to August 29. Course for Part II of the degree of Master of Surgery, January 13 to April 3; course for Part I of this degree, September 1 to November 7. Courses for Parts II of the Diplomas in Gynecology and Obstetrics, Laryngology and Oto-rhinology and Ophthalmology, January 13 to April 3; courses for Parts I, September 1 to November 7. Course for Part II of the Diploma in Psychological Medicine, January 24 to October; course for Part I, March 24 to November. Course for Diploma in Anaesthesia, March 24 to August 29. Courses for the Diploma in Radiology (radio-diagnosis and radiotherapy), March 24 to November 28. Course for Part I of the Diploma in Dermatology, March 24 to May 16; course for Part II of this diploma, June 9 to August 29. Course for Diploma in Clinical Pathology, July 21 to October 10.

The Post-Graduate Committee reserves the right to limit enrolments in any of the above courses and candidates are requested to make early application.

Visiting Lecturers, 1947.

A series of short talks will be given by Sir Heneage Ogilvie, K.B.E. ("Hernia"), Professor B. A. McSwiney ("Sensitivity of the Abdominal Viscera") and Professor Geoffrey Hadfield, examiners for the primary F.R.C.S. examination, on Wednesday, January 15, at 8 p.m., Stawell Hall, 145, Macquarie Street, Sydney.

Sir William Fletcher Shaw, visiting examiner for the M.R.C.O.G. examination, will give a lecture on "The Manchester Operation" on Friday, February 28, and a further

lecture on "Pre-Operative Preparation" on Wednesday, March 12. Both these lectures will be held in the Stawell Hall at times to be announced.

These lectures form part of the annual general course conducted by the committee, the fee for which is £1 1s. per year and includes attendance at all regular film afternoons, lectures *et cetera*.

Country Courses, 1947.

Armidale, March 8 to 9; Katoomba, March 15 to 16; Albury, May 3 to 4; Broken Hill, June 14 to 15; Lismore, August 2 to 3; Wollongong, September 22 to 23; Parramatta, October 18 to 19; Newcastle, October 25 to 26. A course will be held at Wagga Wagga during the autumn of 1947 and at Orange towards the end of the year.

Information on all post-graduate courses may be obtained on application to the Course Secretary, Post-Graduate Committee in Medicine, 131, Macquarie Street, Sydney. Telephones: BW 7483, B 4606.

Australian Medical Board Proceedings.

NEW SOUTH WALES.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Practitioners Act, 1938-1939*, of New South Wales, as duly qualified medical practitioners:

Dey, Judith Elizabeth, M.B., B.S., 1946 (Univ. Sydney), Sydney Hospital, Sydney.
Doherty, John William, M.B., B.S., 1946 (Univ. Sydney), Balmain and District Hospital, Balmain.
Donnan, Bruce Winston, M.B., B.S., 1946 (Univ. Sydney), Sydney Hospital, Sydney.
Downie, David Alfred William, M.B., B.S., 1946 (Univ. Sydney), Wallsend District Hospital, New South Wales.
Duffy, Brian Thomas, M.B., B.S., 1946 (Univ. Sydney), Mater Misericordiae Hospital, North Sydney.

THE J. T. WILSON MEMORIAL FUND.

THE following contributions have been received for the memorial fund for the late Professor J. T. Wilson.

University of Sydney Medical Society, £20.
Professor A. N. Burditt, £10.
Dr. Edward Rivett, Dr. B. T. Edye, £5 5s.
Mr. I. J. Hunter, £5.
Dr. H. H. Schlink and Dr. M. Mulvey (joint contribution),
Dr. Joyce Stobo, Dr. W. F. Simmons, £2 2s.
Dr. S. R. Dawes, £1 1s.
Total: £52 17s.

Contributions may be sent to Professor A. N. Burditt, Anatomy Department, University of Sydney, or to Mr. I. J. Hunter, New Medical School, University of Sydney.

THE FEDERAL MEDICAL WAR RELIEF FUND.

THE following contributions to the Federal Medical War Relief Fund have been received:

New South Wales.

S. L. Cameron, L. S. Corner, F. G. Steele, £10 10s.
N. M. Kater, F. W. Walton, £10.
M. Brenner (second contribution), £8 19s.
N. H. Saxby (second contribution), £7 10s.
W. S. Brooks, Karen T. Helms, £5 5s.
Total: £78 9s.
Grand total: £16,085 9s. 6d.

Medical Appointments.

Dr. W. J. Whitchurch has been appointed Government Medical Officer at Julia Creek, Queensland.

Dr. R. T. Allan has been appointed a member of the Police Medical Board, Victoria, in accordance with Section 7 of the *Police Regulation Act, 1928* (No. 3750).

Dr. F. J. O. Colahan has been appointed a member of the Medical Board of Victoria, in accordance with Section 3, Subsection 1, of the *Medical Act, 1928* (No. 3730).

Dr. R. A. Isenstein has been appointed honorary clinical assistant to the Sterility Clinic (Male Section) of the Royal Adelaide Hospital, Adelaide.

Dr. J. R. Magarey has been appointed assistant medical superintendent (Surgical Branch) of the Royal Adelaide Hospital, Adelaide.

Books Received.

"The Chest: A Handbook of Roentgen Diagnosis", by Leo G. Rigler, M.D.; 1946. Chicago: The Year Book Publishers Incorporated. 8" x 5½", pp. 352, with many illustrations. Price: 52s.

"Diseases of the Skin: For Practitioners and Students", by George Clinton Andrews, A.B., M.D.; Third Edition; 1946. Philadelphia and London: W. B. Saunders Company; Melbourne: W. Ramsay (Surgical) Proprietary Limited. 9½" x 6½", page 944, with many illustrations. Price: 75s.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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